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VETERANS' ADMINISTRATION MEDICAL FACILITY CONSTRUCTION PROGRAM

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

NINETY-NINTH CONGRESS

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VETERANS' ADMINISTRATION MEDICAL FACILITY CONSTRUCTION PROGRAM

THURSDAY, APRIL 10, 1986

U.S. Senate,
Committee on Veterans' Affairs,
Washington, DC.

The committee met, pursuant to notice, at 9:43 a.m., in room SR-418, Russell Senate Office Building, Hon. Frank H. Murkowski (chairman of the committee) presiding.

Present: Senators Murkowski, Cranston, and Rockefeller.

Also present: Senator Mathias.

OPENING STATEMENT OF CHAIRMAN MURKOWSKI

Chairman Murkowski. I would like to open officially the Senate Veterans' Affairs Committee hearing. I apologize for starting late. Unfortunately, I was giving an opening statement this morning on the floor of the Senate, and the presiding officer was taken away under some emergency. And as a consequence I had to preside over that until just now. So I do apologize for any inconvenience.

I want to welcome you all to the hearing this morning, particularly General Turnage. It's a pleasure. You're the newly confirmed Administrator of Veterans' Affairs, and this is your first opportunity to appear before this committee in your new capacity.

We welcome you. Obviously, we look upon you as the captain of the team. It reminds me of the reference to the individual who was named captain of the javelin team and some committee or another appointed him to be the first receiver on that.

You can judge for yourself whether indeed you fit into that category, but I would suggest that there is probably some exposure.

Now, for the past 3 years this committee has been engaged in discussions, both formal and informal, with the Veterans' Administration, about its medical facility construction program. I think it's generally safe to say that we're not totally satisfied with the answers that we have received in the past.

On the other hand, we do want to compliment the associates in the VA who have attempted to develop programs with regard to the changing role within the VA for medical facilities, and the changing needs of the veterans as well. We understand the difficulties in any organization when the base continues to change.

But I deem it fair to say that there is a continuing need for reexamination, and we look to you and your associates for that.

In the past we have posed questions about nearly every aspect of VA construction, the planning, the organization, cost, future direction, and today we're going to continue those discussions. We're going to be emphasizing such areas as the number of people in the VA construction program. I understand there's nearly 700 involved in that.

The Veterans' Administration has indicated that roughly 53 percent of its medical facilities are over 30 years old. There is a need of modernization, a need of replacement. It's estimated that in 4 years from now about 25 percent of all veterans will be 65 years of age or older. The needs of that age group obviously are going to dictate changes in medical care programs.

With these important factors in mind, we are going to have ask—will the VA be able to address and meet the changing needs of the aging veterans in this country? The Congressional Budget Office, April 1984 report "Veterans' Administration Health Care: Planning for Future Years," projected that if veterans request and receive care at the same rate as today, the real costs of providing care could almost double with in the next decade. Due to the budgetary constraints we know this is not a realistic option. So, what are some of the alternatives? This is something that's a little tough to do.

So we ask the VA how they intend to meet these changes. The VA's report, "Caring for the Older Veteran" released in July 1984, was a thoughtful and comprehensive look at the options for meeting both acute and long-term care needs of the veterans' population.

A few of those options have been selected as part of the strategy outlined in this year's budget request. The VA intends to place additional emphasis on State and community nursing homes, and increase the use of alternatives institutional-based care.

But are these efforts sufficient? Does the community have adequate resources to assist the VA with its long-term care needs? The VA must, of course, balance carefully its allocation of resources to acute care and long-term care services. In that regard, why in times of limited resource and a growing elderly population, does the VA continue to devote a significant portion of its major construction budget to the replacement of expensive, acute care hospitals? This question has been asked before, General Turnage.

Could not some of those funds be channelled to long-term care services? Does the VA place a higher priority on acute care perhaps at the risk of not meeting the long-term care needs of the elderly veteran?

We note the importance of these questions, especially in light of the few long-term care options in our Nation. Neither Medicare, nor private health insurance policies generally cover these services. The VA role in the area is, of course, that much more important.

We know that certain communities have excess hospital beds. Limitation in resources dictate that if the VA is to meet the needs of eligible veterans, alternatives to building new expensive replacement hospitals will have to be developed.

It is vital that serious consideration be given to the concept of purchasing or leasing existing facilities, and that this consideration be a regular part of the VA construction program.

The use of standardized hospital components would reduce design and construction costs in cases where VA construction is determined to be the very best option.

Noninstitutional community based care would add a humane and cost-effective option to the VA's continuum of care. Share agreements with the Defense Department and the private sector should be increased, and their scope certainly could be expanded.

If the VA availed itself of these opportunities, the VA's health care system would be more comprehensive, more cost effective, and would ensure that both acute and long-term care needs are met.

During the 1985 committee's construction hearings, I asked if the VA had one document describing its long-term strategic plan for the entire system. I was told that there is a medical program plan developed by the medical districts for all VA hospitals. And there is a 5-year construction plan. But these two planning cycles and the respective documents are not linked in a single strategic plan. The General Accounting Office will tell us today that developing such a link is critical to effective long-term strategic planning.

Last year Senate bill 876, which was initiated from the staff with amendments and became Public Law 99–166, required the VA to develop a 5-year strategic plan for the operation and construction of medical facilities.

It's my understanding that this provision will not be implemented.

In light of information that will be presented during this hearing, I would ask you, General Turnage, to look closely at the need for one comprehensive planning document which would include medical program and construction plans, reevaluate the VA's decision in this matter, and expedite the implementation of the law.

It would also be useful if the plan could address leasing and purchase options, alternatives to institutional based care and excess land proposals.

The VA has begun to respond to other concerns raised by Congress concerning construction programs.

First, the prototype nursing home has been developed; however, concerns have been raised that the prototype has never been used, and we're curious to know why. Perhaps the VA could shed some light on that in this hearing.

Second, a methodology to prioritize construction project is now in place. I believe it would be useful if the VA were to develop a similar methodology to prioritize State Veterans' Home projects.

Third, the VA has developed the proposal to reorganize the construction staff in Central Office. How many staff are necessary in view of the changing constructions requirements under the VA proposals currently before us?

I'm certainly pleased that the VA has taken the initiative to address the concerns raised by Booz, Allen, and Hamilton, and the General Accounting Office, which encouraged certain structural improvements such as the proposed reorganization. I'm also curious to know whether these services could be done effectively under a private contractual relationship as opposed to maintaining that fixed overhead on the staff of the VA.

I know that General Turnage has not had an opportunity to review this proposal in detail. I, therefore, would ask you to keep in mind my concerns and that of the committee as you consider the various aspects of the proposal and recognize the reality that we are required to review the priorities continually on the basis of evaluating what programs can be restructured to provide veteran care.

Any reorganization proposal, of course, must include a detailed plan, a timetable for implementation of changes in the construction planning process and procedure. Proposals that, first, do not adequately address the implementation of process changes are, of course, incomplete. The proposal currently under consideration only addresses organizational or structural changes.

I believe that structural changes are important so that the accountability and responsibility for the construction program fall in the one place, and the ones responsible can be identified and held accountable as they should be. At the same time the strategic planning process changes must be implemented prior to any organizational change. Any reassigning of personnel without this important step would be premature.

And I would point out that in this rather general statement covering areas of concern, it's not the intent of myself or members on the committee to do anything more than objectively look at the resources we have and see if those resources can be deployed.

Some suggest that any changes of VA procedure are efforts to diminish the role of the VA, change or alter the role, or reduce the basic responsibility of the VA. That is not the case. It's simply that budgetary demands dictate a certain reality, and that reality is that we review the resources we have.

I'd like to clarify what may be a misconception of my views concerning hospital mission changes and/or closings. It's my strong belief that the VA should make the most efficient use of its resources. As I've said, in cases where hospitals are underutilized, and there are now five hospitals with occupancy rates at or below 60 percent, I believe mission changes and closings should be a viable alternative. In a time of constrained resources I would much rather see the VA exercise its authority to take such steps than to skim off the top and lay off personnel and risk damaging the quality of care throughout the system. To leave open empty beds does a disservice to veterans in other parts of the country who do not have access to VA or other health care services. And the alternatives are obviously to move the veterans or change the use of those facilities to meet the changing needs of the veterans, such as specific health care for the elderly veteran.

I would look forward to working with you, General, in your new and challenging capacity, and on behalf of the entire committee we look forward to your initial presentation. I would call on my colleague, Senator Cranston, for an opening statement.

Good morning, Senator.

OPENING STATEMENT OF SENATOR CRANSTON

Senator **Cranston**. Thank you very much, and good morning to you. Good morning to all of you present.

It's a pleasure to join with you, Frank, in welcoming all our witnesses to this hearing on VA construction issues.

It's a particular pleasure to welcome the new Administrator, Tom Turnage, in his first appearance in that capacity before this committee, and to welcome and congratulate Gerry Neumann as the new Office of Construction Director.

This marks the first year that we will be operating under the authorizing committee construction project approval process as revised last year in Public Law 99–166. Under the revised process the Veterans' Affairs Committees are required, in order for our recommendation to have a binding effect in the appropriation process, to report identical construction approval resolutions. Thus, we will be working more closely this year than we may have in the past with our counterpart committee in the other body on these issues.

My position regarding the importance of the VA health care system is abundantly clear. I am wholeheartedly committed to the maintenance and continuing improvement of an independent VA health care system. I am convinced there is no better way for the Nation to meet its obligations to those veterans disabled during their service than through the VA system.

However, in this time of very limited Federal resources, there is tremendous competition for funding for VA construction projects. Thus, we must take steps to insure that the projects that are proposed for construction in any given year are the projects most in need of funding. That is a major purpose of this morning's hearing.

In addition to that responsibility, we must examine carefully the administration's construction project proposal to insure that it treats in an equitable and adequate fashion the very pressing need for keeping the VA health care system capable of providing the quality and quantity of care needed for our Nation's veterans now and in the future.

Quite frankly I do not believe that the construction proposal submitted by the administration for fiscal year 1987 is sufficient for that purpose. That is why along with other members of the committee I recommended to the Senate Budget Committee in February that an additional $35 million be made available to the VA's major construction program.

The other Democratic members and I recommended that these additional funds be used for the construction of two new VA nursing home care units in Hampton, VA, and Tampa, FL, and for the purchase of land in Palm Beach, FL, for the future construction of a new medical center.

In addition, funding would be available for the design of a clinical addition at Huntington, WV, and for the construction of two additional levels of parking at the San Francisco VA Medical Center, a long delayed project that I am interested in, and have been frustrated by, for nearly 4 years.

I note that four of these projects, and six others, were identified for fiscal year 1987 funding in the VA's most recent 5-year medical facility needs assessment, but were not included in the administration's fiscal year 1987 budget request. The administration's proposal not to proceed with these projects would, if followed, mean that they will be delayed at least a year, and almost certainly would result in the delay of other projects in the years to which these would be postponed.

This is of serious concern to me in terms of the impact of the resultant slippage on the VA's health care system.

Mr. Chairman, I want to thank you for including on this morning's agenda my bill, S. 2141, to prohibit the VA from declaring as excess several parcels of land at the two VA medical centers in southern California.

On February 5, the VA's then-Acting Administrator, Everett Alvarez, advised the House and Senate Veterans' Committees of the VA's intention to declare these lands as excess to the agency's needs. He further noted that the GSA estimates that $360 million in revenues would be generated by the disposal of this acreage, and that this amount is reflected as savings in the present fiscal 1987 budget.

I believe that this OMB-forced proposal for the excessing and disposal of this VA property is a bad idea for several reasons that I spelled out in my floor statement on March 5, when, together with Senators Matsunaga, DeConcini, Mitchell, and Rockefeller, I introduced S. 2141. Similar legislation has been introduced in the House of Representatives by the chairman of the House Veterans' Affairs Committee.

This morning I will be exploring with the VA the current status of this land disposal proposal, including the preliminary results of a new survey of the land's present and future utility to the VA that has been undertaken by the agency.

Mr. Chairman, I ask that there be included in the record of this hearing the text of S. 2141 and my introductory statement.

Chairman MURKOWSKI. Without objection.

Senator CRANSTON. Thank you.

[The text of S. 2141 and the introductory statement appear on p. 72.]

Senator CRANSTON. In addition, I would ask that an excerpt from the Democratic members recommendations to the Senate Budget Committee on this issue also appear at an appropriate place in the record.

Chairman MURKOWSKI. Without objection.

[The excerpt appears on p. 75.]

Senator CRANSTON. I look forward to all of our witnesses' testimony this morning. In the event that I'm not able to remain for the entire hearing, I will be submitting some written questions for written answers. And I thank you all very much.

[The questions and responses appear on p. 377.]

Chairman MURKOWSKI. Thank you, Senator Cranston.

We will now proceed to hear from Hon. Tom Turnage, head of the Veterans' Administration. We look forward to your testimony, and wish you a good morning.

Please proceed.

STATEMENT OF THOMAS K. TURNAGE, ADMINISTRATOR OF VETERANS' AFFAIRS, VETERANS' ADMINISTRATION, ACCOMPANIED BY EVERETT ALVAREZ, JR., DEPUTY ADMINISTRATOR OF VETERANS' AFFAIRS; DR. JOHN W. DITZLER, CHIEF MEDICAL DIRECTOR; ROBERT E. LINDSEY, JR., DIRECTOR OF OPERATIONS; GERALD E. NEUMANN, DIRECTOR, OFFICE OF CONSTRUCTION; SUSAN LIVINGSTONE, ASSOCIATE DEPUTY ADMINISTRATOR FOR MANAGEMENT AND ACTING ASSOCIATE DEPUTY ADMINISTRATOR FOR LOGISTICS; ALAN MAURER, EXECUTIVE ASSISTANT TO THE DEPUTY CHIEF MEDICAL DIRECTOR; AND MARJORIE QUANDT, ASSISTANT CHIEF MEDICAL DIRECTOR, OFFICE OF ADMINISTRATION

Mr. TURNAGE. Mr. Chairman, Senator Cranston, I'm delighted to see you again. Thank you for the opportunity to appear before your committee.

With me today are Mr. Everett Alvarez, Deputy Administrator; Dr. John Ditzler, Chief Medical Director; Mr. Robert Lindsey, Director of Operations; Mr. Gerald Neumann, Director, Office of Construction; Mrs. Susan Livingstone, Associate Deputy Administrator for Management and Acting Associate Deputy Administrator for Logistics; and Mr. Alan Maurer, who is here in Dick Falco's place since Dick retired just last week.

Mr. Chairman and members of the committee, I'm pleased to appear before you this morning to present testimony concerning the VA's construction program. With your permission, I will summarize my formal testimony and provide additional comments.

Chairman MURKOWSKI. You may proceed.

Mr. TURNAGE. The full text of my statement describes the VA's fiscal year 1987 construction authorization request, and other issues requested in your letter to the VA announcing this hearing.

I appreciate your committee allowing me some time to review the proposed reorganization of the construction program before hearings are held on that issue.

I intend to complete that review as quickly as possible and communicate any concerns that I have to this committee.

As you know, the VA has tremendous capital investment in its medical facilities represented by over 5,000 separate buildings. Our construction program represents a commitment to maintaining a physical plant capable of delivering high quality care to our Nation's veterans.

The fiscal year 1987 budget requests a program level of $465,170,000. This amount includes an appropriation request for a major program of $358,200,000, which includes $57,000,000 that is available from previous appropriations. We are requesting approval for funding in major medical projects. Five million dollars for the advanced planning fund to develop future year projects, $9.9 million for asbestos abatement, and $19 million for the design fund.

We are requesting funding for construction of major replacement facilities at both Augusta, GA, that's the uptown division, and Baltimore, MD.

Projects in the fiscal 1987 construction budget address programmatic needs identified by the medical district initiated program planning process, referred to as MEDIPP. These program plans are based on each medical district's assessment of programs and facilities needed to care for those veterans who use the VA health care system in their district.

These plans are reviewed, modified, if necessary, and approved in the VA Central Office.

The agency construction budget development process has been improved this year by the development of a new methodology to assist in prioritizing major construction projects. This methodology was used to rank the project in the fiscal 1987 budget proposal currently before you, and will be used in future budget submissions, as well as in the development of the 5-year medical facility construction needs assessment.

I would note, however, that this system does not supplant the need for executive review by the Chief Medical Director and by the Administrator of Veterans' Affairs

Mr. Chairman, my formal testimony addresses issues concerned with lease or purchase of existing facilities as an alternative to VA construction, delegation of projects, financing of parking facilities, the impact of fiscal 1986 Gramm-Rudman reductions, VA-Department of Defense sharing activities, and the excessing of land at the West Los Angeles and Sepulveda Medical Centers.

In the interest of time I will not comment on these issues at this time except to say that I reviewed the construction program. These other initiatives will be carefully considered.

I will strive to identify and enhance those efforts that one, increase the degree to which finished construction products support the VA mission, and two, decrease the cycle time, and third, provide for the most economical result for the Government.

I'm particularly pleased with the progress being made by the VA and the Department of Defense to jointly plan in many areas for the benefit of both agencies, and ultimately the taxpayer.

This concludes my formal statement, and I and members of my staff will be pleased to respond to any questions that you or the committee members may have.

[The prepared statement of Mr. Turnage appears on p. 76.]

Chairman MURKOWSKI. Thank you, General. We appreciate your summary and your entire statement will be entered into the record as if read.

I have several questions, and I'm sure that Senator Cranston has questions too.

Let me start with a couple of proposed replacement hospitals. I believe your Baltimore hospital will cost about $121 million, and your Atlanta, GA, Hospital is somewhere in excess of $90 million.

Assuming that's correct, we're looking at somewhere in excess of $200 million on these two programs.

Can you ascertain for the committee the need for those hospitals, recognizing that in the case of Baltimore we have an outdated facility that obviously is in need of replacement, from the standpoint of additional hospital beds being available in the Atlanta and Baltimore areas.

Have you done an evaluation of facilities and communicated with the private sector to make a determination of what their particular capabilities are? And determined whether there's any interest in utilizing existing facilities in either of those cities?

Mr. TURNAGE. Mr. Chairman, please allow me to say at the outset that from the standpoint of procedure, technique, and desire, it's normally my function to respond to most questions, particularly where they have policy implications.

I have brought additional members of my staff this morning simply because having only 2 weeks in the system, and they can provide more detail being involved in that. With your concurrence, I'll ask Dr. Ditzler to assist me with it.

Chairman MURKOWSKI. All right; I might just add to that question that I posed, whether the Department of Defense also has medical facilities available within those two areas that may have the ability to complement the need of the proposed Atlanta, GA, and Baltimore facilities?

Dr. DITZLER. Mr. Chairman, with respect to Baltimore, this project has been in the pipeline for discussion for many years. In fact, I recall it going back into 1977 when I first was on the scene in Washington for other reasons.

The particular question of need, I think, is well established when one considers the grossly deteriorating condition of the hospital at Loch Raven.

The number of beds being surplused in Maryland, the issue of whether we had interest in achieving a result with the private sector, was approached several years ago before my coming in this present tenure. And it was deemed at that time that there were nonacceptable arrangements in the private sector.

The number of beds in Maryland is a critical issue. However, when we complete the building of a new Baltimore VA Hospital, the VA will have decreased the number of beds in Maryland. So we do not believe that we are adding beds, but rather we are correcting the state of the beds.

Chairman MURKOWSKI. Well, I'm told that a study conducted by Booz, Allen, whom you're familiar with, which done for the State of Maryland, indicated an excess of beds in the State of approximately 5,126 to 15,600. That was the range.

They also concluded that by 1988 Baltimore should get rid of 2,585 beds in order to rid hospitals of low-occupancy rates. That's pretty startling in comparison to the statement that you made, which I gathered was an evaluation that had been done some years ago.

Now, I guess my question is, Has there been any update from the VA? In other words, has there been a current analysis? And are you referencing your comments from those?

Dr. DITZLER. I'm referencing comments from the past, and also the fact that at the moment there have been no offers made to us from the private sector that I know of to buy any of their hospitals.

Previous review indicated that hospitals that were available really were not satisfactory to our needs.

Chairman MURKOWSKI. When was this, Doctor? Do you know when this previous review was done?

Dr. DITZLER. I believe somewhere in 1984, prior to my coming. I can submit that for the record.

[Subsequently, the Veterans' Administration furnished the following information:]

Veterans' Administration personnel did visit and inspect the Maryland General Hospital in July 1982 in response to that facility's interest in transfer to the VA as an alternative to new VA construction. It was determined at that time that the facility could not be appropriately modified to meet the VA's program requests.

Chairman **Murkowski**. Do you think it's appropriate that a cursory review be initiated to see what the extent of the private sector availability might be?

Dr. **Ditzler**. I believe, sir, that the fact that the private sector grossly overbuilt their beds in fact is really not the responsibility of the Government or the Veterans' Administration. We have been very careful not to overbuild, and, in fact, the number of beds we will build will be even less than we currently have.

Chairman **Murkowski**. Well, I think one can take that statement either way. It isn't necessarily the issue of who is responsible here anymore than it's a reasonable question to ask why the VA continues to operate hospitals that have the utilization that's extraordinarily low. We do it because we do it.

Now, the question of whether it's the VA's responsibility to consider the position of the private sector is not the question. The question is, Is it conceivable that the VA can provide the level of health care that's required by looking at an alternative, such as the availability, in the private sector, of facilities that can do the job at less cost than building new facilities?

It's simply a reality, Doctor, that I think we all share that there's not going to be enough money here, and it's not just for construction, it's for the VA needs. If we can provide further VA needs by going into the private sector, it behooves us to make the examination. That's a position that I think is a responsible one. And it's a position that I again would reiterate as we contemplate this construction project in both Baltimore and Atlanta.

We acknowledge the decrepid facility, and recognize that it can't be utilized any longer. It would seem to me that prudence would dictate that a current evaluation be made. We can then satisfy ourselves one way or another before there is an appropriation because if there's any savings, obviously it can be put to use in a very meaningful manner in homes, and health facilities for the aged veteran. We haven't even begun to start on that dilemma.

Dr. **Ditzler**. We are developing, sir, a process for examining the issues you mention. With respect to the private sector the purpose of not applying it to Baltimore, is that it could additionally hold up the building of Baltimore, which we think would be costly.

Chairman **Murkowski**. I'm going to pursue this, Doctor, because I feel prudence dictates that you initiate immediately some kind of a review in Baltimore of the private sector. I don't see why it has to take over 30 days to initiate. I don't see why it has to hold off the decision on whether you can go ahead with Baltimore or not.

Now, is there a reason that that can't be done?

Dr. **Ditzler**. Not to my knowledge.

Chairman **Murkowski**. Well, is there an acknowledgment that the VA will conduct that review.

Mr. **Turnage**. Mr. Chairman, I can suggest now we will conduct such a review.

[The information requested appears on p. 89.]

Chairman MURKOWSKI. I appreciate that, and I assume that we will have within the next 4 to 6 weeks a report from the VA.

Would that include also the Atlanta, GA, facility?

Dr. DITZLER. Thank you, sir, because I was having a problem with Atlanta.

Chairman MURKOWSKI. I will leave Atlanta—I won't mention it.

Dr. DITZLER. Augusta is a separate problem, sir, in that it is currently a two division hospital. The one hospital, which is the more acute care facility has been replaced, and is in the downtown section of Augusta.

The one that is to be replaced next is the second division, which is an antiquated old structure that essentially houses all long-term patients.

The problem in the private sector is that there's nothing available that houses long-term care patients, and that's primarily the purpose of the replacement. It is an old antiquated psychiatric hospital that is literally a fire trap; it has no way to feed patients; and it's in abominable condition.

So I think the problem of Augusta is an entirely separate issue.

Ms. LIVINGSTONE. Mr. Chairman, if I could add to that as well.

In fiscal 1985 the VA received $12.4 million in funding for working drawings phase 1 of the construction of Augusta. So in this case the final design for the project has been completed, and active site development and some renovation work are already underway. There are some contracts already for approximately $10 or $12 million on that project. So it's much further ahead with respect to the Baltimore projects

Chairman MURKOWSKI. You have done a current evaluation as to what the capabilities of the private sector are?

Ms. LIVINGSTONE. Not in the Augusta area. The policy of the VA to look at the aternatives of lease or purchase of existing facilities applies to all replacement modernization projects in the future.

In the cases that we're discussing now, we're talking about projects that have been previously funded, are ongoing, or were in the pipeline.

Chairman MURKOWSKI. I know, but you spent $14 million in planning, but that still doesn't mean that an evaluation of the private sector just to satisfy yourself one way or another would be a costly effort. I would think could be done, and would satisfy, if indeed you can substantiate the need, which I assume you can, criticism from those that suggest that we're not initially looking into the private sector to see what's available.

Ms. LIVINGSTONE. Mr. Chairman, I believe General Turnage has indicated we will be doing a review of the facility at Baltimore, and I believe we can certainly conduct a review of the private sector facilities, available in the Augusta, GA, area as well.

Chairman MURKOWSKI. I'd appreciate that.

Ms. LIVINGSTONE. We'll try to complete it within a 30-day period.

[The information requested appears on p. 39.]

Chairman MURKOWSKI. My time is up. I would call on Senator Cranston.

Senator CRANSTON. Thank you very much, Mr. Chairman.

I'd like to take a moment to try to clear up perhaps once and for all the matter that continues to perplex and mystify many of us.

I have one very straightforward question to pose. Is the so-called list of 10 medical centers set forth annually in the VA's 5 year needs assessment as being currently judged most in need of construction, is that a listing of these centers in any particular priority order? That is, is the first item on the list the top priority, and the 10th priority, or what?

Dr. DITZLER. Senator Cranston, I'm going to ask Mr. Robert Neary, who is with me, to construct that list with our guidance, of course, but he's the most knowledgeable.

Mr. Neary, please.

Mr. NEARY. Senator, relative to the list of 10, the list was initially developed in fiscal year 1979. Title 38 does require that it be presented in a priority order.

Senator CRANSTON. Did you say it does require it?

Mr. NEARY. Yes, sir.

Senator CRANSTON. They are listed in priority order?

Mr. NEARY. They're listed in the priority order that we've established; however, we have not prioritized them using the newly developed methodology for prioritization.

Senator CRANSTON. Thank you. That explains it.

Then I'd like to ask this question. How do you justify proceeding with projects that appear in the sixth and eighth position on the list, Augusta, GA, and Baltimore, MD, respectively, before proceeding with even the design phases of projects that appear in the fifth and seventh positions on the same list, Pittsburgh, PA, and Gainesville, FL, respectively?

Dr. DITZLER. Well, I think part of the problem, Senator Cranston, is that the priority lists were established way back in 1979. We have gradually taken off the top the most urgent ones. But in the interim we are finding in recent demographic changes that the veteran population has changed in various areas. We also found that some of our hospitals are deteriorating much more rapidly than we had originally thought.

Senator CRANSTON. Well, the first list was prepared, I guess, back in 1979, but was resubmitted in January 1985, so you'd think that it would then have the priorities as of January 1985, or December 1985.

Dr. DITZLER. That's correct. But I think part of the problem is that we know from the preliminary markups of budgets that we will not have enough money to do everything in the priority, and, therefore, it is sometimes related to the dollar amounts that will be available for construction.

Senator CRANSTON. But you don't have money in for design, which is not that expensive, but you have money for construction, which is expensive. It's not clear how you've been proceeding with any sense of priority.

Dr. DITZLER. Well, in the sense we have tried to reinstate, for example, we placed as a priority this year the preparation of a site in Florida, but it didn't make the clearance, the total budget figure, and so it dropped off of the fiscal Year 1987 budget list although it was on the high ten list.

Senator CRANSTON. Thank you very much.

On page 4 of your prepared statement, Tom, I note with respect to the VA's prioritization methodology, that "this system does not supplant the need for executive review by the Chief Medical Director and the Administrator to insure the circumstances and conditions which might not be addressed by the methodology are considered in formulating agency priorities."

Could you explain what types of circumstances and conditions might not be addressed by the prioritization methodology?

Mr. TURNAGE. What would be the conditions, Doctor?

Dr. DITZLER. There are various conditions. For example, one that comes to mind is Waco, which in the last year has been cited for gross fire and safety deficiencies that required us to put that project ahead of those projects that were even on the list because it was a crucial need.

There are occasions in the process of building a hospital where we get an opportunity to install something new that is on the scene, such as a magnetic resonance imaging device. To go back and do it at a later time is extremely costly. There are changes that occur year by year that make certain things more expeditious, and oftentimes less costly to introduce at that time.

Senator CRANSTON. Are you talking in part about political considerations like OMB or White House or Congress?

Dr. DITZLER. I guess as a realist that fits the general picture of some of the considerations. Whether they weigh heavily or not is not my decision.

Senator CRANSTON. The DAV and the PVA in their prepared testimony note that a recently completed audit by the Inspector General reported serious flaws in the development beginning in 1983 of an acceptable prototype nursing home care unit, and concluded that the VA had not yet accomplished its objective of developing a nursing home prototype for providing quality, timely, and cost-effective facilities to meet the long-term care needs of veterans.

What are the major flaws in the nursing home prototype?

Dr. DITZLER. The first major flaw was lack of agreement as to whether the room should be essentially 235 square foot per single room, or whether it should be 250. Most of the medical profession persisted in saying that it had to be 250. That raises cost.

The reason the medical profession insisted on that is if you have two wheelchair patients in a room you simply couldn't move around.

So the argument is raised for quite a while as to the size of the room. I think we've resolved that now.

The next problem is the number of bathrooms of a prototype that should accommodate wheelchair patients. Our original intent was to build a nursing home that would accommodate spinal-cord injury patients in several rooms.

But the debate then came whether all or only some of the bathrooms should be so equipped. That became the second problem.

By the time we resolved all these things we are now in a position where we're no longer building elective nursing homes, So that the occasion for using the prototype will be very limited.

Senator CRANSTON. Tom, let me address this to you.

I understand the complexity of these issues. But it doesn't seem logical it should take 3 years to resolve questions like that.

Who is supposed to make that decision? Why does it take so long?

Mr. TURNAGE. I can't give you all the history involved with it, Senator Cranston, but there are a number of questions I've already asked attendant to the discussions and the briefings that I have received as to why certain actions can't be expedited.

One of them relating back to my confirmation hearing was the process we go through, for example, to establish a cemetery in northern California. We have that in route now, and we think we are going to be able to place a substantial amount of time in getting the ultimate product.

I can't answer all the details with regard to some of the issues that what you bring up except to point out that what you are interested in—reflects priorities to me that I intend to follow up on.

Senator CRANSTON. I appreciate that, and I hope one of your priorities will be to figure out ways to expedite these decisions.

Dr. Ditzler, you just said that we're no longer building elective nursing homes. What does that mean?

Dr. DITZLER. In the 1986 budget, 1987, and 1988, we had previously proposed the building of four nursing homes in each of those years.

Subsequently, we have changed our philosophy of how we can approach the budget changes of the future, and we are essentially no longer building VA nursing homes wherever we can find sufficient nursing home beds in the community, and in State veterans' homes.

So that there are no nursing home construction projects placed in the 1987 and 1988 budgets

Senator CRANSTON. When will the prototype be completed?

Ms. LIVINGSTONE. Senator Cranston, there are still a number of complex issues yet to be resolved. I believe we're nearing resolution of those, and would be presenting those to the Administrator for his consideration, and also would hope that we'd be able to coordinate where we're at with Paralyzed Veterans of America as well.

So I hope very much that in the near future, the next month or two, we will be able to bring that to resolution.

Senator CRANSTON. Tom, do you think we can resolve this in the next 60 days?

Mr. TURNAGE. Yes, sir.

Senator CRANSTON. Thank you.

If the Congress provides funds for the Tampa and Hampton projects, will the prototypes be available to be used for those projects in fiscal 1987?

Mr. TURNAGE. That's our intention, sir.

Senator CRANSTON. As to each of the four nursing home projects that were identified for fiscal 1987 funding in the 5 year plan, but for which funding was not requested in the budget, Tampa, Hampton, Mountain Home, and Marion, please tell us what were the adequate alternative means of meeting the needs of long-term care beds that were identified?

Dr. DITZLER. With respect to Tampa and Hampton, we did not have a satisfactory alternative, which is why we believe that we need to continue to support the concept of the Tampa project, primarily because it is in a State where they already have no excess of community nursing homes, and they do not have a State veteran home program.

So that we believe that we will in all likelihood continue to press for Tampa particularly.

Senator CRANSTON. In 1984, the VA provided the committee, upon our request, the draft prospectus for the Philadelphia and Baltimore projects, although funds were not then being requested by the administration. Following up on that request, would you please provide us with a draft prospectus for each of the 10 projects identified for fiscal 1987 funding in the VA's December 1985 5-year plan which were not included in the VA's fiscal 1987 budget request?

Mr. TURNAGE. We will do that, sir.

Senator CRANSTON. Thank you.

How long will it take to get those to us?

Ms. LIVINGSTONE. Senator, prospectuses normally are not prepared for the projects unless they're actually entering a budget. We will be able to have the data I assume in probably 5 working days.

[The draft prospectuses appear on p. 114.]

Senator CRANSTON. Thank you.

I think you know, Tom, the situation at the VA's medical center in San Francisco relating to the construction of 120 bed nursing home and a parking structure is one that I am deeply involved with now for about 4 years.

Needless to say, it's been a totally frustrating and exasperating experience.

I'd like at this point to clarify exactly what the agency's position is in that regard.

Am I correct that it's your position that the VA cannot proceed with the construction of the new nursing home facility unless a four-tiered parking structure is also built?

Dr. DITZLER. At a minimum two-tiered. Four would be better, but a minimum two-tiered parking simply has to be available on that site.

Senator CRANSTON. What further actions are you planning to take now in order to make it possible to proceed with the nursing home and the parking structure?

Ms. LIVINGSTONE. Senator Cranston, during the course of the fiscal 1987 budget hearings we have been raising this issue. As you know, it's one that requires resolution by both Committees on Appropriations. It's our understanding that the House Appropriations Subcommittee will be providing us some feedback or resolution on this issue some time hopefully in the near future.

We've been living with you on this issue for the last number of years, and we also hope it can be brought to resolution very quickly.

Senator CRANSTON. Have you made it clear to them that we can't go ahead with the nursing home unless the parking——

Dr. DITZLER. Senator, I have made that statement in open hearing also at the House Veterans' Affairs Committee.

Senator CRANSTON. Thank you. I want to turn now to the administration's proposal to declare as excess and sell off parcels of land at the two southern California VA medical centers.

As we discussed at your confirmation hearing, Tom, under section 5022(d) of title 38, you, as Administrator, have the special, independent responsibility with respect to excessing VA land. Specifically, VA land may not be declared excess and disposed of by GSA unless you determine that the property is no longer needed by the VA in carrying out its function. This is your call, not GSA's, or OMB's.

We agree on that point, do we not?

Mr. TURNAGE. We do.

Senator CRANSTON. As you'll recall, in your confirmation hearing you committed to making your own independent judgment regarding the two southern California land proposals after you get the results of the new land utilization assessment now being made by the VA, and I trust you still plan to do so?

Mr. TURNAGE. I plan to do so, sir.

Senator CRANSTON. What is your present timetable? That is, when do you expect the land utilization assessment results to be available for your review, and when do you think you can make the decision?

Mr. TURNAGE. In the briefing which occurred last evening, I was informed that the team has returned from its review, and that some time this week or next week, they will be able to give me the results of their finding. After that I then will have an opportunity to make a determination and to determine the consistency of what they find with what action has been taken up to this time.

There are many aspects of that that I don't know about, and you can appreciate I may even elect to go take a look at it myself.

But in any event, at some early date I'll be glad to share those views with you, sir.

Senator CRANSTON. Fine.

Mr. TURNAGE. Now, at the outset, this morning we did not plan to bring Mr. Alvarez, the Deputy, here, but we did so simply for the purpose of responding to any questions regarding the background of this that he would have been intimately involved with as opposed to my giving it to you secondhand.

Senator CRANSTON. Fine, I appreciate that.

In response to questions I posed to then-Acting Administrator, Ev Alvarez, in connection with our committee's February 25 hearing on the 1987 budget, he responded on March 26 as follows.

> Even if any adjustments have to be made as a result of this new survey of the land proposed for excessing, there is sufficient excess property available in the VA system to meet the President's objectives.

You also stated that you were sure that "the President's goal can be met."

Since the GSA has estimated that the value of the land proposed to be sold of those two medical centers is $360 million is it the agency's position that in the event these parcels are not declared in excess, there exists $360 million worth of excess property elsewhere in the VA system?

Mr. ALVAREZ. Mr. Cranston, with respect to the property at the west Los Angeles facility, we feel that there is property which is clearly excess to our future or foreseeable needs.

We don't know how much. We won't know how much until that report comes in.

I think if we fail to identify any of that property as excess, we will then be in a severe bind to identify other property in the VA system in the foreseeable future until we do a survey throughout the system.

At this point, without excessing some of that property at the west Los Angeles facility I think we would be hard pressed, very hard pressed.

Senator CRANSTON. Are you under a mandate to come up with $360 million?

Mr. ALVAREZ. That $360 million figure is the target that was part of the President's target for fiscal year 1987.

Senator CRANSTON. It's a target, but do you consider yourself under a mandate to find $360 million worth of property you can label excess?

Mr. ALVAREZ. In my discussions with the counterparts at Office of Management and Budget, I don't consider it a strictly hard line. We'd like to meet that target though we do have flexibility.

Senator CRANSTON. I'm done, except I'm assuming that you, Tom, will consider that a goal. But if you can't meet it realistically and logically, and with due consideration of all your responsibilities, you just won't be able to meet that goal.

Mr. TURNAGE. Yes, sir.

Let me also suggest something which was covered briefly but perhaps another comment would be appropriate at this time.

I'm fully aware of the chairman's view, and of your view, and of the chairman of the House Veterans' Affairs Committee, with regard to the excessing of property which is currently under the control of the Veterans' Administration.

And I have no mandate, nor do I have any charge to excess any property.

I think that the principal issue here is to retain any property that for the present, or for the foreseeable future, could conceivably be used to the advantage of the Veterans' Administration system. And I would think it would be poor policy to dispose of it and then later have to buy it back at inflated prices.

On the other hand, let me suggest that philosophically I agree with the idea that where we do find property that is clearly excess to the needs of the system, that it should be put to other uses.

So that determination I understand is my call, at least my recommendation, and that's the philosophy I intend to follow, sir.

Senator CRANSTON. Well, you made a very, very fine statement of the way I think you should approach it, and it's finally your call, and that's the way the law envisions it. Thank you very much.

Mr. TURNAGE. Thank you, sir.

Chairman MURKOWSKI. Thank you, Alan.

Senator CRANSTON. Thanks for the extra time.

Chairman MURKOWSKI. Senator Rockefeller has joined us and, Senator, we have had opening statements, and a statement by the new director of the VA, the Honorable Tom Turnage. We are in questions at this time. Do you have any questions?

Senator ROCKEFELLER. Mr. Chairman, I do. Does the chairman need any more time to ask questions?

Chairman MURKOWSKI. The chairman has not even started yet.

Senator ROCKEFELLER. Haven't even started. I would welcome hearing those, sir. I need a few more minutes, if that's all right.

Chairman MURKOWSKI. Do you have an opening statement?

Senator **ROCKEFELLER**. Yes, for the record, please.

Chairman **MURKOWSKI**. Thank you.

[The prepared statement of Senator Rockefeller appears on p. 69.]

Chairman **MURKOWSKI**. I would just like to indicate to you that with regard to our conversation on the Baltimore and Augusta hospitals, that funds have not been approved for Palm Beach and Pittsburgh. I would like to request that those two receive an evaluation on the basis of the availability of private-sector capabilities. I don't think that has the same time priority, but within a reasonable time period we would like to have your analysis of those as well.

Is there any objection to that, gentlemen?

Mr. **TURNAGE**. No, sir, we will comply.

[The information requested appears on p. 89.]

Chairman **MURKOWSKI**. Thank you.

I also want to note and compliment you and your associates for the way you have cooperated in meeting the needs of the Air Force by utilizing the facility in New Mexico. The VA has entered into an agreement with the Air Force to provide them with the sixth floor of the facility in New Mexico. I think that's an outstanding example of cooperative effort. I want to commend you, Dr. Ditzler, and your associates, and you, Tom, as well.

Mr. **TURNAGE**. As you know, sir, there are three such things going on, and others under consideration. One in Elmendorf in Alaska, and one at Nellis in Nevada, and then, of course, the one in New Mexico.

Chairman **MURKOWSKI**. Thank you. I do recognize that. Of course, you're well aware that we do not have a veterans' hospital in Alaska, so the utilization of these other facilities, Department of Defense, certainly makes sense. We also have utilization of the facility in Wainwright, as well as the one at Elmendorf.

I have a series of questions. I'm going to try and move through them rather rapidly, and hopefully we'll both be successful.

Relative to the new proposed hospital in Palm Beach, has the VA considered building an outpatient clinic, or a nursing home? Could inpatient services be referred to the VA facility in Miami, or Bay Pines?

Dr. **DITZLER**. Mr. Chairman, I think they already are being referred because we have a gross shortage of facilities in the State of Florida. The number of veterans eligible for care in Florida far overwhelmed all of our facilities in Florida.

There is definitely a shift of the demographics of veterans from the North Central, and the Northeast United States to the——

Chairman **MURKOWSKI**. What's the occupancy rate of Bay Pines?

Dr. **DITZLER**. Bay Pines I think is approximately 70 percent, which would imply that they could take more. Bay Pines has recently been involved with the activation of its new facility and is in transition from primarily a long-term care facility to a modern health care facility.

The interest in making it more effective will also be supported by an affiliation arrangement that has been proposed. We have just now recommended as of yesterday that we go ahead with an affiliation with the University of South Florida to implement better coverage of the Bay Pines facility.

I think you will see that the occupancy rate will improve.

Chairman MURKOWSKI. I'm a little confused because Bay Pines is acute care. And I gathered that you're putting long-term care in it, and it's 70 percent occupied. I would assume with the general retired population in Florida that you could fill it up with long-term care.

Dr. DITZLER. The long-term care does not show up in the acute hospital occupancy. That's the problem. We have two big nursing homes, we have two big domiciliaries, at Bay Pines and I would suspect they're probably 90 some percent filled.

I'd have to supply that for the record, but general occupancies are a difficult thing to come to grips with. For example, many of our system hospitals now are having the problem of determining the difference between occupancy and beds available for new admissions.

For example, 400 bed hospital has 300 patients. It would appear that the occupancy rate is 75 percent. However, there may only be 10 beds available for admission of new patients because in a two bedroom there may be a woman, and only one woman per room. In another series of two bedrooms, we may have patients with infectious diseases. We have an increasing number with AIDS. And those beds are simply not available for occupancy then.

So although the occupancy rate in that case shows 75 percent, the beds to which you could admit to probably would mean you had, in effect, a 90-percent occupancy.

Chairman MURKOWSKI. Well, I understand the technical problems that you have in that regard, but I'm wondering in reality if the needs in Florida would dictate long-term care as opposed to the contemplation of the new Palm Beach acute-care hospital. And as you indicate, Bay Pines is acute care.

My question again is, should you be considering a nursing home facility or an outpatient clinic as opposed to a new hospital. Are these viable alternatives? Are there seasonal fluctuations in hospital occupancy in Florida because of a movement of retired people? I don't know.

Dr. DITZLER. We do have the snow bird syndrome in Florida, there's no doubt of that. But we also, I think, have a misconception, Mr. Chairman, that I will address, and that is I do not agree that we need to deemphasize acute medical care just because we're talking about old folks.

If there's any one thing modern health care has done is extended the life of older folks, and has done it by acute care methods. It has done it by operating on people that are 70 that 10 years ago wouldn't have been touched and are now surviving into their eighties.

So the idea that old people should be essentially warehoused in long-term facilities I think has been a misconception of a lot of the public, and it is true that once the old folks lose their ability to sustain their own home, they do need alternate methods of care. But I think in terms of health care as opposed to the total social welfare and support of the older folks, we still dramatically need to provide the acute care that they need. They even need more acute care.

[Subsequently, the Veterans' Administration furnished the following information:]

The cumulative FY 1986 hospital bed occupancy rate in Medical District 12 (Florida) through March 31, 1986 is 75.1 percent. VA Nursing Home and Domiciliary occupancy for the same period is at 93.7 percent and 89.0 percent respectively. Occupancy at the Bay Pines facility through March 1986 is 78.7 percent in the hospital bed sections with 95.4 percent and 89.0 percent in the hosspital bed sections with 95.4 percent and 89.0 percent respectively in the Nursing Home and Domiciliary bed sections.

Current occupancy, however, has very little relationship with projected need for beds in Florida. The projections that are driving the future need for hospital beds are based on projected population, and perhaps more importantly, the age mix of that population. Several publications including VA's own "Caring for the Older Veteran" have highlighted that persons over age 65 tend to utilize acute hospital facilities twice as much as their younger counterparts. The July 1, 1982 issue of "Journal", published by the American Hospital Association, (page 53) noted that the elderly were responsible for 94 percent of the growth in inpatient (hospital) days between 1970 and 1979. The Journal of the American Gerontological Society in an article published in February 1982, also noted that the 65 to 74 year age group had twice as many acute hospital discharges. Planning for future health care needs must be based on what we know about hospitalization rates among various age groups. Our rapidly aging population makes current hospital bed occupancy a poor indicator of future need.

Chairman **Murkowski**. Well, I don't think there's any disagreement in the need for acute care, but there is a reality that the need for long-term care is not being met. All I can do in an oversight capacity is to concern myself with the necessity of trying to accommodate both needs. This dictates that in some instances we will not be able to provide acute care in the proximity of the veteran, and we try to accommodate the long-term care in the proximity of the veteran. In many cases this would dictate that we have regional acute care centers, and concentrate on the realities when they receive acute care it may have to be some distance from their domicile. We try to identify and provide long-term care as close to the domicile as possible.

Obviously this is a compromise. I'm told that according to off the record comments by the Palm Beach Health Council, there appears to be a need for nursing homes but not acute care beds in that area.

Now, these are reports that come into the committee, and it's our responsibility to pass them on to you, and your responsibility to evaluate them. I don't like to pass off the record comments, but it is a concern, and you are as aware of the mix as I am.

Other than the Providence Hospital in Mobile, AL, which you're required to study by authorization and direction from this committee, are there any facilities that you are currently considering to purchase or lease?

Dr. **Ditzler**. We currently are discussing with the State of Connecticut the purchase of a State of Connecticut hospital in Farmington, which I believe, is currently run by the university. They want to abandon their hospital and go build another one.

Originally we had proposed a construction project for 1990 that would have used some of their land, but would have also appended it to some of their functions. The cost benefit ratio was not favorable, so we considered staying back at the Newington Campus of our VA, which is 7 miles away.

A Member of Congress, however, has been influencing, I believe, the Connecticut State Legislature for us to consider purchasing that hospital, and that will be under review.

Chairman MURKOWSKI. Would this replace the hospital in Connecticut, or provide an additional hospital?

Dr. DITZLER. This would replace the old Newington VA Hospital.

Chairman MURKOWSKI. That, and Alabama, are the only ones you're actively considering.

Dr. DITZLER. At the moment, sir.

Chairman MURKOWSKI. Have you received solicitations from other hospitals around the country?

Dr. DITZLER. Not at this moment.

Chairman MURKOWSKI. Thank you.

Do you have any reason to provide the committee as to why the VA has never purchased or leased an existing facility?

Dr. DITZLER. I suspect if we had received an offer that we couldn't turn down it would be difficult to defend not having purchased the facility.

I know of no offer that was either economically sound or began to meet the requirements that we have in most VA hospitals.

Chairman MURKOWSKI. So you're still looking for it?

Dr. DITZLER. I'm sorry?

Chairman MURKOWSKI. You're looking for such an offer?

Dr. DITZLER. Well, when such an offer is made I would be receptive to it.

Chairman MURKOWSKI. You're receptive to it.

Dr. DITZLER. I would have an easy time of saying, yes, we have looked at it.

Chairman MURKOWSKI. Each year the VA requests substantial funding for replacement hospitals. If a large percentage of those same dollars were used to build nursing homes, you could possibly have enough beds to accommodate the growing need for long-term care.

Dr. DITZLER. Well, we have an alternate suggestion, sir, and that is that instead of replacing the older acute care hospitals, or increasing them in size to do something different, that we convert them to nursing home beds themselves without the necessity of building a separate nursing home.

Chairman MURKOWSKI. Do you know what percentage of hospital care is nursing home care in actuality? In other words, what percentage of VA hospital facilities have long-term nursing home type patients?

Dr. DITZLER. Senator, let me ask Ms. Quandt if she has off the top of her head the number of census patients we have.

Ms. QUANDT. Senator Murkowski, the average daily census for intermediate care, or long-term patients in our acute beds is 11,490.

Chairman MURKOWSKI. Can you enlighten me a little bit more? That's 11,490 out of——

Ms. QUANDT. Out of our operating number which is essentially 89,000.

Chairman MURKOWSKI [continuing]. 89,000 is your capacity then, and you're running 11,490.

And then out of that 89,000 what's your vacancy factor?

Ms. Quandt. System wide we are functioning at 80 percent.

Chairman Murkowski. So it's about 60 percent.

Ms. Quandt. The vacancy rate varies from facility to facility.

Chairman Murkowski. I understand.

So you're running 67,000 beds?

Ms. Quandt. Yes.

Chairman Murkowski. So you got 67,000 beds of which 11,490 are—

Ms. Quandt. Are long-term care.

Chairman Murkowski. Are long-term care. So it's about one-sixth.

Ms. Quandt. Yes.

Dr. Ditzler. One-sixth.

Chairman Murkowski. What was it 5 years ago and 10 years ago?

Dr. Ditzler. Greater.

Ms. Quandt. May I supply that for the record, sir? It is greater as Dr. Ditzler has stated.

[Subsequently, the Veterans' Administration furnished the following information:]

Total VA beds (hospital and nursing home) fiscal year		Program or bed section	VA census fiscal year		Community nursing home care and State home census fiscal year	
1975	1980		1975	1980	1975	1980
101,607	92,539	Intermediate [1]		9,433		
		Nursing home	6,739	7,933	10,345	14,115

[1] Not separately identified in fiscal year 1975.

Chairman Murkowski. It is greater now.

Dr. Ditzler. No; greater before.

Ms. Quandt. It was greater previously.

Chairman Murkowski. It was greater previously for long term?

Dr. Ditzler. That's correct.

Ms. Quandt. The number has dropped over several thousand in the last 3 to 4 years because of the strategic management program, which is moving the system to the vertically correct integration. We are moving more patients out to nursing homes rather than retaining them in the hospital.

Chairman Murkowski. Is that private nursing home care or VA nursing home care?

Ms. Quandt. Both.

Dr. Ditzler. Both.

Chairman Murkowski. Can you tell me what percentage is private and what percentage is VA.

Dr. Ditzler. Well, we increased VA nursing home beds in the last 9 years by some 3,000 beds.

Ms. Quandt. Our current census for VA nursing homes is over 9,000. They have approximately 16,000 patients any day of the year in either community nursing homes, or State nursing homes.

Chairman Murkowski. So you've got 9,000 in the VA, and 16,000 in the private sector?

Ms. Quandt. Right.

Chairman MURKOWSKI. Is it increasing in the private sector?

Ms. QUANDT. It will increase. Our market share is being changed so in the future it will be 30 percent VA, 40 percent in the community, and 30 percent in the State homes.

Chairman MURKOWSKI. Well, I guess our question as we review in an oversight capacity the acute care responsibility is, How can we better maintain the integrity of the acute care system by funneling more of the long-term patients out, and maintaining that care that we must maintain with the highest quality, and the highest rate of efficiency?

Dr. DITZLER. Mr. Chairman, I'd be happy to supply to you a think tank conference that we held in January of this year in which we have projected by 1992 that that's exactly the way we will be going. We will be decreasing the number of tertiary care centers, and increasing the number of other primary referral centers, which essentially deals with the long-term problem.

Chairman MURKOWSKI. We have a reality of two Senators that are going to be heard; Senator Rockefeller and Senator Mathias who just joined us. We have a vote on. I'm going to take the option of leaving and voting. Senator Mathias, have you voted?

Senator MATHIAS. No; I'm going to go vote also.

Chairman MURKOWSKI. Well, does anybody want to proceed now?

Senator MATHIAS. I'm just really here to listen.

Chairman MURKOWSKI. You missed all the good part. We just moved off Baltimore. But we can go back to it.

Senator MATHIAS. Can I just ask a quick question?

Chairman MURKOWSKI. You may proceed, and after Senator Rockefeller, why, Senator Mathias, and then the chief of staff will take over until I come back.

Senator ROCKEFELLER. General Turnage, I want to be very brief and specific. Actually parochial is a better word.

First of all, I really appreciate the quick response I got from you responding to my questions during your confirmation process. Your promptness was not typical, and again was very impressive, and I appreciate that.

Mr. TURNAGE. Thank you.

Senator ROCKEFELLER. Your testimony referred to the average age of VA hospitals being about 30 years old. I think you probably know that the one in Huntington is about 50 years old, and is, in fact, I believe one of the first ones constructed in the system.

Huntington's VA medical center does not have any psychiatric beds. It does not have either beds or spacing arrangements for extended care. It has a very antiquated operating room setup and an enormous number of other deficiencies. As Senator Cranston said in his remarks, this committee wants to restore $35 million for construction in fiscal year 1987. Knowing that you have a number of other proposed major construction projects for the near future, does the first phase of the Huntington Medical Center clinical addition stand a chance of getting underway in fiscal year 1987 should this additional money be added to the budget?

Mr. TURNAGE. I'm not sure you were present, sir, when I made an opening comment to the chairman. I normally would prefer to answer such a question forthrightly, and quite personally. I don't have the background for that now, but I have confidence in Dr. Ditzler, and perhaps he can respond to that.

Dr. DITZLER. I think it would stand a very high chance, as you may know. We had it originally in our top priority for the 1987 budget, but the budget level just happened to go sort of through the middle of Huntington. So we at that point deferred to do the whole thing as one project, and it would certainly be the high priority at the moment for our fiscal 1988 budget.

Now, with respect to the statement about the additional money, I'm not privy to that information, but I'm sure that if I had the money I would think highly of Huntington.

Senator ROCKEFELLER. Seems fair enough.

Would it be possible, General or Doctor, for you and/or some members of your staff to go with me to the Huntington Hospital while we're in the process of making this decision. Would such a visit be possible?

Mr. TURNAGE. By all means.

Dr. DITZLER. Same here.

Senator ROCKEFELLER. That would be great.

This is a particular problem—and everybody has particular problems—but this is my State's particular problem.

Mr. TURNAGE. The part of the commitment we're making, sir, is that we'd be glad to visit with you.

Senator ROCKEFELLER. Great. Thank you very much. I've got to go vote.

Mr. PRINCIPI. General, if you have no objection, I will continue for the chairman so that we can move on with the other witnesses.

Thank you very much.

General, Dr. Ditzler, it has been said that the VA's close working relationship with medical schools across the country drive the construction program and the need to maintain a wide variety of services at each hospital.

In your view, does the affiliation with medical schools, in fact, drive the VA's construction program?

Mr. TURNAGE. Allow an opening remark and then I'll allow the expert to follow up.

I'm simply suggesting that the statistics probably bely that fact. There are 172 hospitals, and there are 101 of them that are affiliated with those schools, and I would suggest that points out that one may not drive the other.

However, I do recognize the value which is derived both by the Veterans' Administration, as well as the site as a whole, from this kind of relationship. Beyond that, I think specifics can be addressed by Dr. Ditzler.

Dr. DITZLER. Mr. Chairman, I really don't believe that academe drives the VA. I think the VA is independent and makes its own decisions. And I will have to agree that where there is an option of building a VA hospital 10 miles from a medical school, or next door, we clearly would want to build it next door for many practical reasons.

But as to the size and shape of it, and the cost of it, I think the only driving force is that acting in consort with medical education opportunities, we do provide more space obviously for conference rooms, and teaching labs in a VA hospital that is in an active affiliation than one that is not.

So I would have to say that overall the influence of academia in driving the decision is almost zero. The impact on education and affiliations on the total cost of the structure is probably a little greater, but not the driving force.

Mr. PRINCIPI. Thank you.

At last year's hearings on VA medical facility construction, the Hospital Corp. of America testified that their cost to build a new hospital was approximately $150,000 per bed. The VA will spend, I believe the chairman stated, about $121 million to build a 324-bed facility in Baltimore. It will cost the VA $373,000 per bed, or about $223,000 more than it would in the private sector.

Do you agree with those figures, and if so, why is the difference so great?

Dr. DITZLER. Well, I think it's a different ball game, sir. First of all, most private hospital buildings today are built to be amortized in 20 years. Most VA hospital structures are built for a 40-year period.

Second, most VA hospitals are built using every known Federal requirement that serves other public purposes. That includes EEO, labor union contracts, et cetera, whereas many of the private hospitals are often built with nonunion labor, and built with foreign steel, and I think that all adds up to a difference in cost there.

We have a social responsibility in government of demonstrating compliance with those requirements. So I think it's true that the costs are probably greater.

But I think one ends up comparing apples and oranges in many other ways. We provide for different functions. For example, last year we had in the VA health care system 13 million hours of volunteer service, which equates to about 130 millions of dollars of savings to the U.S. Government. To provide this, we need space in hospitals to provide services that ordinary private hospitals don't offer or build for. Our volunteers provide bingo and other entertainment for the long-term census patients, and these things add special requirements.

When we add the obligation to research and medical education that we provide for this country, we additionally have space problems that cause a greater concentration.

In the Baltimore hospital in particular, we have a unique problem of parking. The average private hospital would have a private corporation build a garage, and run it, and have the fees and everything on itself. There is no parking in the area for the VA, so it's in part of the basement structure, and that increases the cost of the original building, but on the other hand, it's going to provide a service to veterans and their families that would not otherwise be provided. So I think it's an apples and oranges thing.

Mr. PRINCIPI. Doctor, I have two related questions, and I do want to touch upon the parking situation because certainly the members have expressed great concern with the lack of adequate parking throughout the country. San Francisco certainly is of primary importance.

With regard to the medical school affiliations and leasing and purchasing existing facilites, when you're going to replace a hospital like Baltimore, and you're going to consider leasing or purchasing, would that option be overshadowed by the affiliation and the need to have the hospital close to the university medical school?

Dr. **DITZLER**. I think I would make a judgment there based on what it's going to cost the U.S. taxpayer, and second, whether we are able to complete our mission of education and research on an equal footing.

I really can't deal with a hypothetical because I don't know whether you're talking about a block away, 10 miles away, and the transportability of people. Certainly that would be the driving factor, not the affiliation per se.

Mr. **PRINCIPI**. With regard to parking in Baltimore, I believe it's proposed to spend $10 million for a parking facility in Baltimore, and that comes out to about $15,000 a parking space.

How can you justify such an exhorbitant cost for a parking space?

Dr. **DITZLER**. I'll have to call on my engineer friends. Susan, do you want to touch that?

Ms. **LIVINGSTONE**. Mr. Chairman, frequently—when you're incorporating parking into a basement structure, or into a part of the facility that's being constructed, the cost per space is quite high.

In terms of the particular Baltimore design, I'm not sure if we're running into hard rock there, if there are specific conditions that would create that, and I would call on Gerry Neumann, our new Director of Office of Construction, to see if he might be able to elaborate on that.

Mr. **NEUMANN**. I think it's that question we concentrate a little bit more when we have a very serious water condition at the Baltimore site. If you go down there you'll know parking is very expensive.

However, as Dr. Ditzler pointed out, there are no alternative solutions in that immediate area.

Ms. **LIVINGSTONE**. I might note that this is a cost estimate, and obviously we would hope that when the actual bids come in and contractors are putting forward their price quotes, we might be able to effect a much lower price than that.

Chairman **MURKOWSKI**. I'm curious about this 90,000 hospital and nursing home beds that the VA is required to maintain. What does that mean? How does it breakdown?

Dr. **DITZLER**. Mr. Chairman, I believe by law we are to maintain a total of 90,000 operating beds.

Chairman **MURKOWSKI**. Is that acute care beds?

Dr. **DITZLER**. No, sir, it is simply a statement of the number of beds in this system that we will operate, and these are generally defined as hospital and VA nursing home beds.

Chairman **MURKOWSKI**. How many do you have?

Dr. **DITZLER**. It excludes the doms, by the way.

Chairman **MURKOWSKI**. It excludes what?

Dr. **DITZLER**. It excludes the domiciliary in that count.

Chairman **MURKOWSKI**. Which means long-term care?

Dr. **DITZLER**. Well, long-term care is done in domiciliaries; long-term care is done in hospitals; and long-term care is also done in nursing homes.

Chairman **Murkowski**. All right. How many beds do you have in hospital and nursing home that apply under the 90,000?

Dr. **Ditzler**. Right now it's about 89,000, and then a few hundred. There are some out of service now for construction. And that's a fluctuating list, so we're approximating 89 plus that are actual operating beds.

Chairman **Murkowski**. Is it practical that there should be a change in this law, that you should have more emphasis on outpatient care and that the domiciliaries be counted for purposes of determining 90,000?

Dr. **Ditzler**. I don't think, Mr. Chairman, that the number per se means anything except that it is a target area that we're required by law to approximate, at least.

[Subsequently, the Veterans' Administration submitted the following additional material for the record:]

The Agency's views regarding its obligation under 38 U.S.C. section 5010 to operate 90,000 hospital and nursing home beds is more fully set forth below in a letter of April 23, 1986, to the Chairman of the House Committee on Veterans Affairs.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

APR 2 [illegible]

Honorable G.V. (Sonny) Montgomery
Chairman, Committee on Veterans Affairs
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

We regret the delay in answering your letter of March 5, 1986, asking why VA has planned to operate 88,200 beds in the coming fiscal year instead of the 90,000 operating beds which section 5010 of title 38, United States Code, seems to require the Veterans Administration to maintain.

It appears that the Agency has attempted to maintain the number of beds called for in section 5010. Nevertheless, while acknowledging that those numerical levels are set in law, they must be read in the context of the overall responsibilities of the Administrator and the Chief Medical Director. In view of their broad statutory responsibilities regarding operation of VA's health care system, we believe the Agency is generally meeting its obligations under section 5010 if it maintains operating beds, and other treatment capabilities, sufficient to meet the health care needs of eligible veterans and, in a national emergency, Department of Defense personnel. Certainly meeting that obligation requires careful balancing and oversight on our part.

In addition to what may be viewed as a "minimum bed requirement," the VA is, of course, required to maintain "a complete medical and hospital service . . . for the medical care and treatment of veterans." 38 U.S.C. § 4101(a). Moreover, section 5010(a)(1), imposes other requirements:

> "The Administrator shall staff and maintain, in such a manner as to ensure the immediate acceptance and timely and complete care of patients, sufficient beds and other treatment capacities to accommodate, and provide such care to, eligible veterans applying for admission and found to be in need of hospital care or medical services" [38 U.S.C. § 5010(a)(1) (emphasis added)].

These statutory provisions clearly direct the Administrator to ensure that the VA's allocation of its medical care appropriation allows it to meet all facets of its health care mission, not simply bed-based care.

The provision of outpatient care has, of course, played an increasingly important role in the Department of Medicine and Surgery's (DM&S) fulfilling its primary function as a complete medical and hospital service. Moreover, provisions of law direct the Administrator to operate several specialized programs which by their nature involve primarily noninstitutional services. See, e.g., 38 U.S.C. § 612A, 663; sections 105 and 109, Pub. L. No. 99-166. In essence, it is conceivable that rigid adherence to achieving minimum operating bed levels could compromise the agency's ability to carry out other requirements of law.

Balancing these often-competing statutory demands can be particularly complex in a dynamic national health care system. For example, with ongoing construction, repair, and remodeling of VA facilities, the number of VA hospital or nursing care beds in operation changes constantly. The dynamic processes, which flow from the national scope of VA's health care system, make it difficult to estimate precisely the number of operating beds in the system. At any one time, the possibility exists that the number may be less or greater than 90,000.

In keeping with major health care trends generally, the Department has seen changes in its reliance on institutional care. Our providers have recognized that in many instances the most appropriate health care can be provided through noninstitutional programs. As you know, Congress has enacted several provisions in recent years to enlarge VA's authority to permit us to embark on such initiatives. See, e.g., §§ 103(a)(1) and 104, Pub. L. No. 98-160 and §§ 101 and 104 of Pub. L. No. 99-166. The effects of this shifting emphasis, accelerated by efficiency-oriented management initiatives, has been to reduce dramatically the average length of stay in VA hospitals. This decrease in average length of stay results in VA's treating the same or a greater number of patients with an equal or fewer number of hospital beds.

In essence, VA has made great progress in efficiently providing care, without undue reliance on maintaining veterans in hospitals or nursing homes. The agency has achieved this through the effective use of alternative modes of treatment. These are certainly desirable changes of which Congress has been aware and helped foster.

Another imperative for the efficient operation of the DM&S is the recognition that the Agency must begin to prepare to meet the need for nursing home care of an increasingly aged veteran population. Yet budgetary restraints require that cost effective means be found to meet that need. As you know, our 1987 budget reflects a long term care policy which would place increased reliance on the State home and the community nursing home care programs as more cost-effective vehicles of long-term care. By furnishing a greater volume of care through VA-sponsored community providers and State homes, VA nursing home care can be expanded at a significantly lower cost. This budget also permits expansion of our home care and adult day health care programs and anticipates our converting numbers of hospital beds to nursing home care use. If identified long term care needs cannot be met through conversion or through community and State home facilities, new construction will be considered. In essence, while mindful of the bed-levels in section 5010, VA long term care projections are based on most effectively and efficiently increasing the needed resources to deliver that care. Our planning in the meantime is geared to meeting needs for nursing home care while complying with the legislative directives in title 38 for providing specific types of health care, maintaining a complete medical and hospital service, and insuring the capacity to meet the health care needs of veterans.

We do not mean to imply that mere administrative inconvenience or policy choices justify noncompliance with statutory provisions. Ultimately, however, we must attempt to harmonize multiple statutory directives with patient care imperatives and the availability of appropriations. Despite efforts to achieve the 90,000 bed level, we cannot assure that that level can be reached in FY 1987.

Finally, it is important to note that this view of section 5010 avoids the difficult constitutional question presented by section 5010(a)(1), which states that the President shall submit a budget to the Congress sufficient for the Administrator to operate at least 90,000 beds.

On October 13, 1981, as Congress considered section 108(a)(1) of H.R. 3499, subsequently enacted as section 5010(a)(1), the then Assistant Attorney General for the Office of Legislative Affairs informed the Chairman of the Senate's Committee on the Budget:

> In our view, a statutory direction to the President to include any particular request in the budget he submits to Congress would be of doubt-

> ful constitutionality under Art. II, §§ 3 of the Constitution. . . . Under that provision, . . . the President's constitutional role in the lawmaking process includes "the recommending of laws he thinks wise. . . ." [A law] which would require the President to submit certain budget proposals. . . . necessarily subverts the President's constitutional power.

In our view, the provisions directing the President to submit a specific budget proposal and calling for the VA to operate a minimum number of beds are inextricably entwined and pose the same constitutional question. Our view regarding your question about the VA's operating a specific number of beds avoids the need to confront any constitutional issues.

In summary, the Agency is generally meeting its obligation under section 5010(a)(1). Meeting that obligation necessarily requires us to take account of other requirements of law, the availability of appropriations, and the health care needs of our patients.

Thank you for the opportunity to clarify this important question.

Sincerely yours,

THOMAS K. TURNAGE
Administrator

Dr. DITZLER. From a practical point of view, 10 years ago there was an average of 78,000 hospital patients per day. Today that is more like 56,000 hospital patients per day.

So that in terms of matching operating beds, and the requirements for admission, we have currently a surplus of beds in hospitals, and because of that we're proposing that we convert more of them into nursing home and other long-term functions.

Chairman MURKOWSKI. Well, I'm curious that you do not include domiciliary beds in the 90,000-bed requirement.

Is it your recommendation they remain excluded, or would you include them?

Incidentally, let me ask this question. How many do you have anyway?

Dr. DITZLER. The domiciliary beds I believe at this time have dropped from—in the last 5 years from 9,000 to about 5,000. But I'll have to supply that.

[Subsequently, the Veterans' Administration furnished the following information:]

In the past 5 years the number of VA domiciliary beds has dropped from 8,350 to 7,063.

Chairman MURKOWSKI. But they're not in hospitals?

Dr. DITZLER. No; they're on hospital grounds.

Chairman MURKOWSKI. On hospital grounds, but they're in addition to the 89,000.

Dr. DITZLER. That's my understanding, but I'll make sure that you have that for the record.

Chairman MURKOWSKI. Well, those figures pretty much indicate what the person in the back indicated.

Would prefer to continue to leave them out of the 90,000 bed requirement?

Dr. DITZLER. Oh, I don't care.

Chairman MURKOWSKI. Well, I don't either. It's just a case of whether you want to include them in or not from the standpoint of administration.

Dr. DITZLER. Whatever keeps everybody happy is all right with me on that one.

Chairman MURKOWSKI. If we look for whatever keeps everybody happy, why, we'll never finish today's hearing. [Laughter]

Mr. TURNAGE. Mr. Chairman, there is an issue here about interpretation of that requirement. When they speak in terms of 90,000 there is no flexibility given from the standpoint of my interpretation of the law per se.

But to the extent that it would be a flexibility to the system, if that weren't as firm as is currently stated, and we had some flexibility based on changes in the system, or changes on the basis of the construction in progress, all those kinds of aspects, it would be to our advantage, and also indicate an attitude and a spirit to comply with the law if, in fact, we had that kind of flexibility.

Chairman MURKOWSKI. It would seem to me that this additional 5,000 would give you some flexibility.

Mr. TURNAGE. Yes, sir.

Chairman MURKOWSKI. All right; I know this was discussed during my absence, but I would like to hear again the explanation for the Hospital Corp. of America's statement in 1984 that the cost to build a new hospital was $150,000 per bed. The VA will spend at least $121 million to build a 324-bed hospital in Baltimore, at a cost to the VA of $373,000 per bed, or about $223,000 per bed more than it would cost the private sector.

Now, we have been through this before. But I cannot explain it. And I would appreciate a refresher course.

Dr. **Ditzler**. Mr. Chairman, I will try, although I am not the engineer. And I am going to duck this one in part.

But I think I understand finally why some of these things are true. I understand the reality of the private sector putting up a hospital and wanting to amortize it in 20 years. I also understand the obligations of most Federal agencies that they build for a period of 40 years. I also understand that I cannot cut corners in the EEO area, I cannot cut corners in minority and small business contractors, I cannot cut corners in any of the Federal structures rules.

So I think the bottom line is that it costs the Government more to build than the private sector. And that is why we are not, in part, building more nursing homes, because we have found that it is several million dollars cheaper to use the community nursing home than to put up our own nursing homes. That is part of the reason why we have made this change in philosophy.

When it comes to the hospital structure, though, we have unique differences between VA and private sector requirements. We add things that probably would be cut out of a private hospital. Now, that is part of the answer.

The other part of the answer is that the particular area where the Baltimore hospital is going is expensive. And the question of providing parking, which is being built into the basement structure of the building is an additive cost. Therefore, the cost per bed has shot up.

Chairman **Murkowski**. You do not amortize the parking in a fee structure for the personnel in the hospital in Baltimore but you do in other VA hospitals. What is the rationale for having paid parking for employees in some areas and not others?

Dr. **Ditzler**. Well, that is another issue on the whole.

Chairman **Murkowski**. But it appears to be an inequity.

Dr. **Ditzler**. I am going to turn that over to my parking lawyers because it is a complex issue that is difficult to understand, frankly.

Chairman **Murkowski**. That makes two of us. Now we will really be confused if we get the lawyers involved.

Mr. **Ivers**. Senator Murkowski, I am not sure that this is going to respond to your particular question with respect to the Baltimore hospital, but the law would permit us to charge for parking in any VA facility, with certain limitations. However, the money would go back into the miscellaneous receipts or back into the Treasury, not back into VA.

Now, the decision as to whether or not to charge, is a decision that has to be examined on a case by case, facility by facility basis. One not insignificant hurdle to charging for parking is the union contracts which at the present time do not include charging for parking for employees.

Chairman **Murkowski**. Well, it would seem to me that policy would dictate that you have uniformity. Recognizing that you do have some paid parking, it would seem to me that to be exposed to a situation in which you do not charge some and charge others puts you in a pretty difficult position. And it would dictate that you are going to have to provide free parking for everybody.

Ms. **Livingstone**. Mr. Chairman, basically the VA does have a uniform policy of not heretofore charging our employees for parking on site of our VA medical centers. We do have two exceptions to that in the VA system, one is at the VA Medical Center in Memphis which dates back to an old Bureau of Budget agreement the VA had in 1968 whereby the Bureau of Budget at that time provided funding to us to acquire land to provide some surface parking. And as part of that provision they required that we help pay back the money to the Treasury that they were putting forward. At Iowa City it was a distinct situation where the medical center determined that they had very limited parking. In order to allocate that in some more equitable fashion or at least have a formula there, they did start charging for parking. I believe that was back in the early 1970's.

It is something that we do have under review. And we will be coming forward with some options to the Administrator hopefully in the near future.

Chairman **Murkowski**. Well, I think as you review you might look at a law the sharp eagle-eyed people up here have indicated is relative to parking garage facilities. It is stated in section 5009 that, amounts appropriated under the authority of this section, and all income from fees collected for the use of such garages and parking facilities, shall be administered as a revolving fund to effectuate the provisions of this section, but only to the extent provided in an appropriate act. The revolving fund shall be deposited in the checking account with the Treasurer, except that such amounts thereof as the Administrator may determine to be necessary to establish and maintain operating accounts of the various garages and parking facilities.

It would seem to me that you have the availability of a revolving fund. And to use those funds for parking facilities or additions.

Mr. **Ivers**. Senator Murkowski, if I might, the revolving fund has not been activated by the Appropriations Committees or by an appropriations act. It has not been triggered at this point. So it, in our opinion, does not exist. Therefore, we have no place to deposit that money. It must go back into miscellaneous receipts.

Chairman **Murkowski**. Well, the law says to deposit it.

Mr. **Ivers**. It requires that it be triggered by an appropriations act, and it has not been.

Chairman **Murkowski**. Where is that referenced?

Mr. **Ivers**. I think you just read it.

Chairman **Murkowski**. Well, that is not what it says. If it is, I would appreciate a recommendation from the VA and we will request it from the Appropriations Committee and get it.

Mr. **Ivers**. I think we should. That language that says "but only to the extent provided for in appropriations acts" we interpret to mean that unless an appropriations act or the Appropriations Committee provide for that revolving fund and——

Chairman MURKOWSKI. Is that not for the expenditure? We are talking about revenue.

Mr. IVERS. That is if the revolving fund does not exist we take the position we cannot put the money into it; it is not there.

Chairman MURKOWSKI. Well, it says that the laws do exist. Well, let us figure out how we can do it.

Mr. IVERS. It has got to be triggered——

Chairman MURKOWSKI. It seems to me that if you folks would make a request, the Appropriations Committee would be happy to respond.

Mr. IVERS. We are not as confident of that as you are, sir, but we, I think we should make that request.

Chairman MURKOWSKI. Have you tried it yet?

Mr. IVERS. No.

Chairman MURKOWSKI. Why?

Mr. IVERS. I have not tried it.

Chairman MURKOWSKI. Well, has the VA tried it?

Dr. DITZLER. Informally we have discussed this with the staff of the Senate Appropriations Committee with little progress being made.

Mr. TURNAGE. Let me respond this way, Mr. Chairman.

Chairman MURKOWSKI. Have you tried it through this committee?

Mr. TURNAGE. We will try, sir.

Chairman MURKOWSKI. I appreciate that. I think that is the attitude we are looking for.

Ms. LIVINGSTONE. Mr. Chairman.

Chairman MURKOWSKI. Yes?

Ms. LIVINGSTONE. If I might take a moment just to come back to the question that you were raising with regard to the comparison of VA cost per bed to that in the private sector.

Chairman MURKOWSKI. I was just going to get back to that.

Ms. LIVINGSTONE. Good. I will do the opening introduction then here.

One issue that we would like to place before you for consideration is the fact that the VA does compare quite favorably with the private sector on a cost-per-square-foot basis. Frequently, when you are having data comparisons the cost per bed does not really reflect the distinctions and differentiations. And a much more accurate reflection of the construction costs would be the cost per square foot in which we do compare quite favorably with the private sector.

Chairman MURKOWSKI. How do you equate that, though? Cost per square foot?

Ms. LIVINGSTONE. That is right.

Chairman MURKOWSKI. Land is a consideration, granted. But, good heavens, we are talking about $223,000 more per bed.

Ms. LIVINGSTONE. But I think that that ignores what is leading up to those types of statistics which would be the programs that are in there, the spatial configurations to support those programs, and the distinct requirements that are within the hospital structure itself. And I think when you get down to actual construction costs, if you are saying that the VA is way out of whack with the private sector construction costs, why the costs in the VA to build these buildings are so much more, on a square-foot basis it is not, we compare quite favorably.

We have offered in the past and we would welcome the opportunity to do an apples to apples comparison with the private sector on this cost issue.

Chairman **Murkowski**. Well, I do not know that it compares so well. You are not amortizing the costs of some 700 people involved in the hospital planning process, the constructions that are in the nucleus or the bureaucracy of the VA. That is underwritten by the VA separately.

In the private sector they have to include that. And you know it is more. It would be more than $223,000 if you are comparing the two if you amortize the costs of the oversight within the VA and attribute it to each individual project. So I do not think you are reducing it.

Ms. **Livingstone**. We could do that kind——

Chairman **Murkowski**. You are increasing it.

Ms. **Livingstone**. We could do that type of base comparison where we use actual in-house man-hours on a particular project and then incorporate those into the cost comparisons. We would welcome the opportunity to have a real apples to apples comparison with the private sector.

Chairman **Murkowski**. This is something that continues to come up before the committee and there continues to be inquiries directed from the public and private health care services. I do not know how to relate to it other than to have an open hearing where both sides can hear from each other.

More and more we have seen Government beginning to recognize its abilities and inabilities and get out of areas where the private sector can provide the construction cheaper. And I do not dispute the special needs of the VA hospitals. But it would seem to me that in the case of one example, Baltimore, when we are looking at $223,000 more per bed that it is going to raise some eyebrows and we are going to be held accountable.

I think we have to have more than generalities such as the peculiar needs of the VA or some other dictate to justify it.

Dr. **Ditzler**. Mr. Chairman, I think that to be fair the quotation of the American Hospital Association taken across the board of all hospital beds does not necessarily match Baltimore, say, against a comparable hospital which is sitting right next door. I would anticipate in trying to supply you an answer, going to the University of Maryland, and finding out what it cost them per square foot or per bed to build their university hospital, because then I think we would have a much more nearly comparable facility.

I will try to determine that for you.

Chairman **Murkowski**. I think it would be worthwhile to go through that exercise. For a change and see what the differences are and on a fair comparative basis so that we are comparing realistically the same things.

And I would instruct the staff to at some time prepare with the VA for a hearing. And you pick a typical situation and we will have an evaluation of it with the private sector.

Is it generally understood that that would be welcome?

Mr. **Turnage**. Yes, sir.

Chairman MURKOWSKI. Good.

Ms. LIVINGSTONE. Mr. Chairman, we are completing a study of our standards and specifications for construction in the VA as compared to the private sector. I would just note during the course of that, our consultants did have difficulty in obtaining the data from the private sector. So we would absolutely welcome that opportunity and hope that you would help if we required help to obtain the data and that we could call upon you.

Chairman MURKOWSKI. I think we may have had an effort in Houston. But again I do not know how accurate it is. The Hospital Corporation of America actual costs to built a hospital is $150,000 per bed and the VA's proposed hospital in Houston is $250,000 per bed. Whether that is a comparison, I do not know, but that would be the purpose of this exercise.

Why does the Office of Construction need over 700 employees when most, if not all, design and working plans are done on a contractual basis outside the VA? What do these people do?

Ms. LIVINGSTONE. Mr. Chairman, I would ask Gerry Neumann, our new Director, Office of Construction, to expand on this in just a moment. But you need to recognize that the VA is a leader in the United States in terms of medical care facility construction. And as a result, we have a number of individuals that are employed to help develop standards, specifications, new planning techniques and processes to support that program within the United States.

The number of employees in the Office of Construction has been declining in recent years even while the budget is going up.

Now, in point of fact, I think there has been recognition in our own system that we could be more streamlined, more effective in terms of our organizational structures. And that was one of the reasons that we called upon Booz, Allen to come in and take a look at what we were doing, not only procedurally but also in terms of our organizational structures.

Chairman MURKOWSKI. What did Booz, Allen tell you to do with regard to your Office of Construction?

Ms. LIVINGSTONE. Basically, the major substance of the Booz, Allen report was in terms of a number of procedural recommendations for changes in our procedures which they felt would help streamline and clarify decisionmaking responsibilities within the system, which in turn would also lead to probably reductions in terms of personnel.

I do not recall the specifics from the report. But I do not believe that they were anticipating a very large number of reductions in personnel. It was something on the order of 40 to 70, I think, at the time that the full recommendations that they had made were implemented.

Chairman MURKOWSKI. Well, it would seem to me that if, in fact, the VA is contracting for a good deal of these services with regard to design, various working drawings and so forth, that a program of attrition within the VA Construction Office may be cost effective. You figure how much you could save and where you could put those dollars in other priorities, it might be something well worth the effort.

You know, you have got the capability of data processing. I do not know how much it is utilized in your construction program. I do not know what the trend is other than you suggested that overall construction employees are declining. But how high was it and where is it going to go? What is the objective in that area?

I guess it is appropriate that we ask what your plan is as you pursue a scale-down construction program. Is this indeed an area where substantial savings could be realized by contracting these services out?

Mr. TURNAGE. Mr. Chairman, I do not know what the ultimate plan will be, but I know also this issue was covered in some detail in the Grace report and got my attention before I even went to the agency. I have already suggested to Mrs. Livingstone that we are going to discuss this in some specifics. And it is one of the issues that I want to address on a priority basis. I think it is just a matter of time of being able to get to it.

Chairman MURKOWSKI. With respect to the land in California, Senator Cranston and I have a little difference of opinion on what ought to be done with that land. But I think you gentlemen are going to have to make the appropriate evaluation.

It is my understanding that the only projects under consideration for new construction in the West Los Angeles and Sepulveda VA hospitals are relocating the canteen services in Sepulveda and replacing the laundry facilities in Wadsworth; is that correct?

Ms. LIVINGSTONE. Mr. Chairman, I believe there have also been plans to do some relocation of research buildings at the West Los Angeles facility as well. But I would ask perhaps if Bob Neary could confirm that.

Mr. NEARY. Yes. There are plans to relocate the research facilities which are in insufficient older buildings to a new structure.

Chairman MURKOWSKI. That is not in your 5-year needs assessment, is it?

Mr. NEARY. That is beyond the needs assessment timeframe—beyond 1990. The needs assessment goes to 1990, and the research project is planned beyond 1990.

Chairman MURKOWSKI. When did this come up?

Mr. NEARY. It has been some time. I believe it was in last year's needs assessment.

Chairman MURKOWSKI. Was it then or was it not?

Mr. NEARY. It was in last year's needs assessment. And as we have dropped back in terms of our outlook for resources it was one of the projects that was delayed beyond 1990.

Chairman MURKOWSKI. Do you know what the findings of the VA site team—well, I gather you have not had the opportunity to review that.

Mr. TURNAGE. No, sir.

Chairman MURKOWSKI. So I will not do that.

There is a concern over the mission of the two VA hospitals with the lowest occupancy rate located in Miles City, MT, and Walla Walla, WA, with occupancy rates in Miles City, MT, of about 38 or 39 percent, and Walla Walla with 60 or 61 percent.

Dr. DITZLER. Less than that.

Chairman MURKOWSKI. Less than that?

Dr. DITZLER. I think so.

Chairman MURKOWSKI. I would just appreciate your comments.

Dr. **Ditzler**. Well, as a historian, I look back to 1966 when under similar budget constraints efforts were made to close about 20 VA hospitals, many of which were old Army cantonment-type hospitals and were very difficult to run efficiently. I remember that one of those hospitals was Miles City. I also recall historically that the then Senator from Montana and now Ambassador to Japan was very vigorous in support of maintaining Miles City.

As of about a year ago, the IG made critical recommendations to us in the Department of Medicine and Surgery for not having done something about Miles City.

We have proposed, therefore, that we have a change of mission. We find gross inefficiencies in their surgery department. In fact, there are construction needs if we were to continue a surgery program. So we have proposed abandoning surgery and putting those elective cases in other VA hospitals, although at some considerable distance, and emergency surgery be cared for in the private sector at our expense.

We have also proposed to decrease the size of the medical service because it is only 50 percent used and then to convert the remaining beds by a minor construction project into a nursing home for long-term care.

We believe this is responsive. We believe this conserves construction dollars. And we believe it also is conserving of operational dollars.

So to that extent that is what we would like to do.

Chairman **Murkowski**. How much long-term care is being provided in that facility now? Do you have any idea, Doctor?

Dr. **Ditzler**. There are some few beds. But I would have to give you the exact figure for the record.

Long term is a problem in definition in itself. If we are talking about the average intermediate care medicine it may be 30 or 40 days, which in terms of an acute care hospital is long-term care. On the other hand, VA being so well into long-term care already, often defines long term as anything that is over 100 days.

Chairman **Murkowski**. How many beds do you have in the Miles City Hospital, doctor?

Dr. **Ditzler**. I have to ask for help on that. It is probably 100 plus.

Mr. **Neary**. They are currently operating 91 hospital beds and 26 nursing home care beds.

Chairman **Murkowski**. Ninety-one. And your occupancy is around 38 percent?

Dr. **Ditzler**. Something in that area, sir.

Chairman **Murkowski**. So your proposal is to convert that to long-term care. You would bring in veterans from the surrounding areas, I assume throughout Montana then?

Dr. **Ditzler**. Yes; and we would also propose maintaining an outpatient functions.

Chairman **Murkowski**. Have the veterans' organizations given you any support on this or have they been opposed to it or do you know?

Dr. **Ditzler**. Well, there have been hearings and generally nonsupport.

Chairman MURKOWSKI. What you would be doing then would be pulling long-term care veterans from the private sector and putting them in VA hospitals. Is that right?

Dr. DITZLER. I am not certain I understood that question.

Chairman MURKOWSKI. Well, I assume that veterans are receiving long-term care now from facilities that are in the private sector. So you are relieving those facilities that are currently occupied.

Dr. DITZLER. Well, I really cannot answer that. I do not know how many private hospitals have referred long-term patients to that hospital. I would have to get that for the record.

Chairman MURKOWSKI. What are your target dates for implementation?

Dr. DITZLER. Well, we believe in a free, full discussion. And assuming that it proceeds as planned, we would begin implementing this by October, which would be the beginning of fiscal 1987.

Chairman MURKOWSKI. What about Walla Walla?

Dr. DITZLER. Same, same general circumstances as in Miles City.

Chairman MURKOWSKI. We have received, and appropriately so, inquiries as to the necessity to pursue this change of mission. It is necessary that we have accurate information with regard to occupancy, the type of care, utilization, and the number of operations performed and the general data available to respond to those inquiries. I assume that you would be willing to and able to provide us with that based on your own analysis of the cost effectiveness which has resulted in these specific recommendations?

Dr. DITZLER. The specific recommendations in the chain of command at this time have been through the MEDIPP planning process and we are now in the process of briefing veterans' service organizations and also the congressional committee staff. After this has been completed the decision will come to me to recommend to the Administrator, and then it will be his decision as to which he wants to approve.

Chairman MURKOWSKI. Well, I do not mean to imply a short circuiting of your internal system. It would be appreciated if the committee could have the justification because you have generalized pretty much that it is not cost effective and you had proposed a mission change.

Dr. DITZLER. Right.

Chairman MURKOWSKI. And that was based on an evaluation, based on utilization and so forth.

Dr. DITZLER. I believe within the next 2 or 3 weeks at most we plan to brief the staffs of your committees.

Chairman MURKOWSKI. Fine. We would appreciate having that information.

I am also interested in knowing if a mission change is contemplated in the Sepulveda, CA, VA facility? And if so, is it because of low occupancy rates or for other reasons?

Dr. DITZLER. Well, I do not know what the final recommendation will be, sir. But at the moment my intent would be to suggest a mission change.

Chairman MURKOWSKI. The basis for that mission change would likely be what reason?

Dr. DITZLER. Primarily that we have five competing, highly tertiary care, medical care centers in a very short geographic area. And I do not believe that we need five highly tertiary care medical centers. We need more long term. And I believe that Sepulveda would be an ideal location for that. It was designed originally as a HON-type hospital with some 215 buildings scattered all over, and it is ideal for long term as opposed to acute.

Chairman MURKOWSKI. Well, we will look forward to having that recommendation.

I have no further questions. I want to thank you all for participating in, I think, a meaningful examination of the health-care construction program.

Again, Tom, we welcome you as the head of the VA and look forward to working with you as you seek to pursue your charge. We will also look to seeing if we cannot generate a little change in the parking activities by persuading the Appropriations Committee to respond.

I wish you a good day and invite you to participate in the balance of the hearing.

We have next panel 2, Mr. John Cherbini, Associate Director of the Accounting and Financial Management Division of the General Accounting Office. He will be followed by Mr. Winfield Kelly, director, board of directors, Maryland Chamber of Commerce.

Then the fourth panel will be service organizations, Mr. Egan of the American Legion; Mr. Dennis Cullinan, Veterans of Foreign Wars; Mr. David Gorman, Disabled American Veterans; David Passamaneck, AMVETS; and Bob Moran, Paralyzed Veterans of America.

First of all, panel 2, you may proceed. I would appreciate, since we are approaching the hour of noon, if you summarize your testimony if you are able to.

Please proceed.

STATEMENT OF JOHN R. CHERBINI, SENIOR ASSOCIATE DIRECTOR, ACCOUNTING AND FINANCIAL MANAGEMENT DIVISION; U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY WILLIAM O. JENKINS, EVALUATOR IN CHARGE, ACCOUNTING AND FINANCIAL MANAGEMENT DIVISION; AND NORMAN RABKIN, GROUP DIRECTOR, HUMAN RESOURCES DIVISION

Mr. CHERBINI. Mr. Chairman, I am pleased to be here today to share with you our views on several issues in VA medical care and construction planning.

I have with me today Mr. Norm Rabkin, a group director in our Human Resources Division, who is responsible for the VA; and Mr. Bill Jenkins who is the project manager for a project that we recently completed looking at the financial management systems in VA.

I will make only a short statement. However, with your permission I would like to submit a more detailed statement for the record.

Chairman MURKOWSKI. Your entire statement will be entered in the record when appropriate.

Mr. CHERBINI. Thank you, Mr. Chairman.

To improve its medical care planning process, called MEDIPP, VA made a number of changes that will affect the MEDIPP plans submitted to its Department of Medicine and Surgery in November 1985 and plans for subsequent years. Some of these changes, especially the introduction of annual operational planning using budgetary ceilings may provide VA a basis for establishing more realistic goals and a better link with the budget.

These changes do not, however, require planners to systematically consider eligibility categories in identifying future veteran demand for care.

The 1986 Omnibus Reconciliation Act refined those eligibility requirements. And we think VA should use eligibility in medical care planning.

Using these categories would permit VA to identify those groups of veterans least likely to be served within any set of alternative budget ceilings. Furthermore, VA does not systematically estimate the types of illnesses for which veterans may be expected to seek care in the future. While the Department of Medicine and Surgery has provided medical districts a case mix projection model for inpatient care, districts are not required to use it in developing their MEDIPP plans.

Yet, the types of illnesses for which veterans seek care, not just their numbers, determine the clinical resources and facilities needed and the costs to provide them. Even if VA revised its MEDIPP process to do the kinds of analyses discussed, its efforts would be hampered by the weaknesses in its current data. VA does not have accurate per patient clinical and cost data. Until it does VA will find it difficult to assess the clinical resources needed to cost-effectively meet the projected future caseloads and efficiently run their day-to-day operations while maintaining quality care.

For example, a recent study of VA's patient treatment file found that about 35 percent of the major inpatient diagnoses reported were incorrect. Our recent study found that outpatient visits are underreported because VA does not count outpatient clinic visits by long-term and intermediate care inpatients.

Furthermore, we found that MEDIPP Program costs are derived from quarterly workload estimates rather than accounting data. And according to VA, these reports are highly sensitive to error.

Hospitals are trying to reduce the error rate in each of these systems and reports because they use them to allocate a growing portion of their budget.

Turning now to construction planning, the recently completed Booz, Allen, Hamilton study with whose major findings we concur found three major problems with VA's construction planning.

First, medical care and construction planning are not effectively integrated;

Second, current construction planning tends to be focused on individual projects not on developing a national construction strategy.

Third, the process has no clear point of accountability below the VA Administrator.

Both our work and that of Booz, Allen found that the data used in construction planning could be improved. Specifically, Booz, Allen found that VA does not have facility planning standards that reflect current treatment patterns. We found that VA has not defined the basic clinical services that should be available at various types of VA medical facilities, nor have they developed a comprehensive inventory of the clinical services available at each facility or assessed the physical condition of each, although we understand that they are working on all three of these areas.

VA has proposed the merger of the Office of Construction and Department of Medicine and Surgery under the authority of the Chief Medical Director to provide a point of accountability below the Administrator. But such a merger will not produce fundamental improvements unless accompanied by a comprehensive strategy for improving VA's construction processes and for developing more accurate data.

Finally, Mr. Chairman, I would like to summarize the results of our draft report that provides an example of how VA can improve its construction planning by developing criteria based on actual and projected workload at a facility.

In a 1981 study we reported that VA's criteria of one surgical suite for every 28 surgical beds was resulting in construction of too many surgical suites in new or replacement hospitals. We recommended that VA instead use a model that focused on the unique surgical workload of each medical center. However, VA agreed with the principle but not the model.

We understand VA has nearly completed its own model. VA is still using the same criteria it used in 1981. Applying our model, based on actual workloads, we found that VA plans to build 29 unnecessary operating rooms at a cost of $5.8 million.

We have two concerns with VA's proposed new model. First, it does not use a pre-set rate for determining extent of operating room use. We believe 80 percent would be appropriate.

Second, the proposed model allows VA planners to make changes in workload projections without central guidance of monitoring.

We have received comments from VA officials on our draft and expect to issue the report shortly.

In summary, Mr. Chairman, we believe that VA needs to develop a comprehensive strategy for improving medical care and construction planning and the data that those systems rely on.

I would be glad to answer any questions you might have now.

[The prepared statement of Mr. Cherbini appears on p. 139.]

Chairman MURKOWSKI. Thank you.

Evidently, your analysis of the VA's electronic data processing system is not a high recommendation or a high assessment; is that right? There is some question As to their antiquated procedures in processing?

Mr. CHERBINI. Yes, sir. That is correct, Mr. Chairman.

Chairman MURKOWSKI. That evaluation has been made over a period of time or is it just a recent evaluation?

Mr. CHERBINI. I think we issued that report last year, I believe. It was completed and the report was issued last year.

Chairman MURKOWSKI. Can you summarize the report very briefly? What does it say, in effect?

Mr. CHERBINI. Basically, our position was that their systems were antiquated, needed significant improvements, and did not capture the kinds of data that we thought were appropriate for effectively managing a large organization such as VA.

We compared VA somewhat to the private sector in the kinds of information that they capture to manage their hospitals. I do not think we see that there is a lot of difference conceptually in the types of information that VA ought to capture in order to manage the costs of running a VA hospital.

Chairman MURKOWSKI. Well, it is kind of unfair to compare the Government sector with the private sector.

In your capacity you have an opportunity to assess, I assume, a number of other Government agencies' internal capabilities. Is that right?

Mr. CHERBINI. Yes, sir.

Chairman MURKOWSKI. Including the efficiencies of their data processing departments?

Mr. CHERBINI. Yes, sir.

Chairman MURKOWSKI. Who, in your opinion, has an effective and efficient data processing capability to administer services utilizing data processing in the Government sector that is comparable to the private sector? What agency?

Mr. CHERBINI. I think that there are agencies that are beginning to develop systems that have the qualities of information that are needed to manage programs in some agencies. For example, the State Department is currently working on a new financial management system where they are trying to capture the kind of information that would give them the ability to more effectively manage their programs and provide program managers with the kind of comparative information that they need to effectively manage the program.

[Subsequently, Mr. Cherbini submitted the following information:]

> However, no federal agency, to my knowledge, has the type of modern ADP system that produces the program and financial information we believe is needed for effective management. We have noted the generally inadequate state of federal financial management systems in our report, Managing the Cost of Government (GAO/AFMD-85-35, and 35A), which suggests a conceptual framework for modernizing federal financial management systems. The State Department is one agency that is working on new financial management systems that should capture the type of program and financial information we believe are needed for effective management. Such information would also provide more reliable information on program operations and costs for congressional oversight.

Chairman MURKOWSKI. So you would say the State Department.

Mr. CHERBINI. I would say that the State Department is an agency that is moving in the direction and attempting to improve their systems, based on what we see.

Chairman MURKOWSKI. It is pretty hard, though, to compare the State Department with the services offered by the VA.

You know, it is very easy to criticize data processing capabilities. But when you see the overall state of government data processing capabilities vis-a-vis the private sector, why, I think that is where you have to make the cut. I would have no hesitation about accepting your recommendations if you could cite the one Government agency that is in the business of serving people. The State Department's obligation is a little different.

Mr. CHERBINI. Yes.

[Subsequently, Mr. Cherbini submitted the following information:]

Federal agencies are spending, and planning to spend, millions of dollars modernizing their ADP systems, including those for financial management. As part of these efforts, we believe agencies should develop systems that can provide the information necessary for effective management, including cost control. In VA medical care, this means per patient clinical workload and cost data that would permit VA to assess the costs of treating any specific illness or mix of illnesses. VA's new casemix method of allocating hospital budgets places a premium on such information, because it reimburses VA hospitals a set rate for each specific type of illness treated.

In this era of tight budgets, many agencies, including VA, do not have the information they need to assess the cost effectiveness of their operations and reduce costs where possible, while maintaining the highest level of program delivery possible. Such information is needed for effective management, regardless of the types of programs an agency administers.

Chairman MURKOWSKI. How is Health and Human Services? They serve people. Is that comparable to the VA or is it not?

Mr. CHERBINI. I have not looked at the Health and Human Resources.

Chairman MURKOWSKI. Anybody else from your shop? Anybody got anything?

How about the National Institutes of Health? That is a health service. Is that comparable to the VA in data processing capability?

[No response.]

Chairman MURKOWSKI. You do not know.

I would suggest you kind of find out because I do not think it does any good to compare the private sector with the Government sector because you cannot compare. The incentives are different. The entire process is different.

We continue to urge the VA to improve their data processing system. Obviously, money is part of the problem but not all the problem. I think there is a willingness within the VA to accept advancement of data processing procedures. But I do not think that we should generalize in the sense of condemning them for being antiquated when much of the same stick should fall on the backsides of many other Federal agencies.

I think one of the problems of agencies is that they do not have the ability to have a firm come in and set up a data processing system that is functional in the sense of what you should have. If the Senate is any example, God help you. We have three systems now. We probably have four for all I know. And it is a helter-skelter situation. I do not mean to suggest anything more than they have now hired the data processing manager from the State of Alaska to coordinate the entire Senate system. So if it gets better you will know who to put the accolades on. And if it gets worse, why, you will be able to identify the individual. He is on his third day.

That is where they went. He did a hell of a job in the State of Alaska because we had a lot of money and a lot of systems and tremendous chaos. This guy came in and made it work with less money. Now he is going on to greater glory. Although, he may be catching the swords that will be thrown around later.

But I pass that on to you because I happen to have messed around in data processing in the financial field.

Mr. **Cherbini**. Mr. Chairman, may I add to that, I think Mr. Bowsher would agree with you. We have recently published a two-volume report called "Managing the Cost of Government" where we discuss the general state of financial systems in the Federal Government. And we agree with you that in general the systems of the Federal Government are in need of improvement.

Chairman **Murkowski**. I am not convinced that it would not be better for the Federal Government to go out and contract under some incentive program for their data processing. Let somebody else manage the systems and effect the information that is needed.

But anyway, that is another story for another time.

You contend that the eligibility should be a determining factor.

We have instituted the application of the means test. Is that not going to basically take care of the eligibility question? Those that have the means will make a contribution for their health care?

Mr. **Cherbini**. Mr. Chairman, we think that the VA systems ought to be able to capture better information on eligibility so that they can at least have basic information on the number of veterans being treated by those various categories and have the information they need to make priority assessments.

[Subsequently, Mr. Cherbini submitted the following information:]

We believe that VA's systems ought to be able to capture reliable information on the eligibility of veterans requesting and receiving care, and that VA should use this information in its medical care planning. The reason for this is simple. A veteran's priority for access to VA health care is dependent upon his or her eligibility for care when VA facilities cannot accommodate all veterans requesting care. Such information would perit VA to identify which categories of eligible veterans were being served, and the eligibility status of veterans not being served in areas of unmet demand. The need for such information, we believe, is highlighted by the changes in eligibility for care made in the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272, Title XIX).

Chairman **Murkowski**. What, in your opinion, is the most critical recommendation you would make concerning the VA's medical construction program?

Mr. **Cherbini**. In our opinion we think that they need to set a national health-care strategy for VA. And they ought to——

Chairman **Murkowski**. Does any Government agency have a national plan or is this something that is peculiar to VA's requirements? I know we do not have an energy plan, and I serve on the Energy Committee.

Mr. **Cherbini**. No, sir; I am not aware of any other.

Chairman **Murkowski**. Well, it would be nice to have a strategic plan.

Mr. **Cherbini**. Yes, sir.

Chairman **Murkowski**. And that is your recommendation?

Mr. **Cherbini**. Yes, sir; that they would——

Chairman **Murkowski**. The most critical recommendation? Did you make that to other agencies as well?

Mr. **Cherbini**. Yes, sir. We—and as a matter of fact, in our "Managing the Cost of Government" we have recommended that each agency should be able to put together strategic plans in order to determine what their long-term goals and objectives are.

The Defense Department would be the only agency that comes immediately to mind that does have some kind of planning and programming process that we have looked at.

Chairman MURKOWSKI. Well, we certainly do not want to get into their long-term plans either.

The VA states there is a link between medical district initiated planning and the construction planning process. And you say there is not an effective link. I assume the rationale is again no one plan.

Mr. CHERBINI. No one plan, and the data that is not available to support that plan.

Chairman MURKOWSKI. What would you suggest as the major ingredient in a comprehensive long-term plan?

Mr. CHERBINI. I think if we were to suggest that the kind of information that they ought to capture in this long-term plan would be per patient and clinical workload data and cost data, that they have this veteran population and eligibility data, that they have up-to-date clinical inventories and that they have assessed the physical condition of those clinics, and that they have some kind of construction standards and functional standards to support their planning process.

Bill, would you add anything to that? No.

Chairman MURKOWSKI. I have no further questions. Thank you, gentlemen, for your participation.

[Subsequently, Mr. Cherbini submitted the following information:]

The Veterans Administration operates the nation's largest health care system, with some 172 hospitals and their associated facilities, including nursing homes and outpatient clinics. VA expects to provide more than 18 million outpatient visits, and 1.4 million episodes of inpatient care with its approximately $9 billion fiscal year 1986 medical care budget. Managing this system, and planning for the future needs of veterans is a challenge with the best management information possible. But, like many federal agencies, VA does not have the reliable, useful workload and cost data it needs to control costs while maintaining the quality of care it provides to veterans.

Until recently, VA has not had a pressing need for reliable per patient clinical and cost data. Unlike private hospitals, which needed such information for billing purposes, VA did not usually bill veterans for the cost of their care, and did not develop systems that provided data at the patient level. A number of changes in recent years, however, have highlighted VA's need for better clinical and cost data for management of its health care program. VA has, for example, implemented a new methodology for allocating hospital budgets that is based on a measure of both a hospital's clinical workload, and the cost efficiency with which it supports that workload. Under this methodology, more efficient hospitals will gain funds while less efficient hospitals will lose. While the formula measures the cost efficiency with which hospitals treat specific types of illnesses, VA's current workload and accounting systems do not capture the per patient clinical and cost data necessary to evaluate the costs of treating specific types of illnesses.

Additionally, Congress has reduced the rate of growth in VA's health care budget as it has tried to bring down the large, annual budget deficits. Meeting a growing demand for care from veterans in an era of relatively static budgets requires an ability to identify and reduce excessive costs whereever possible.

VA is planning to spend millions of dollars improving its clinical data through the Decentralized Hospital Computer Program (DHCP), and cost data through the overhaul of several of its major accounting systems. We believe it is essential that VA carefully consider the data it needs for effective management of its hospitals, health care planning, and construction planning in redesigning these systems. These systems should at least capture eligibility, income, clinical and costs data on a per patient basis. Eligibility and income data are needed because they are two of the key determinants of a veteran's access to VA health care. Per patient clinical and cost data are essential building blocks for the effective management of day-to-day hospital operations, as well as health care and construction planning. It is the types of illnesses for which eligible veterans are currently requesting care, and are expected to request care in the future, that determines the clinical facilities needed to provide that care. Accurate per patient clinical and cost data can provide VA the information it needs to assess the most cost-effective means of providing quality care for the present and future health care needs of eligible veterans.

While our testimony has focused on VA health care and construction planning, and the data needed for those tasks, we believe that a similar approach to systems upgrades and redesigns in all agencies would yield benefits in better data for program management, including cost control. It would also provide more reliable information for congressional oversight of program and agency operations.

Chairman MURKOWSKI. I would call on Winfield M. Kelly, director of the board of directors of the Maryland Chamber of Commerce.

I am going to have to go vote up in the Foreign Relations Committee.

Mr. PRINCIPI [presiding]. The Chairman had to leave the room to vote at the Foreign Relations Committee. He should be back. However, in view of the hour, we still have another panel, I would like to proceed.

If you will please summarize your testimony. And perhaps before doing so introduce the gentlemen who are accompanying you today.

STATEMENT OF WINFIELD M. KELLY, DIRECTOR, BOARD OF DIRECTORS, MARYLAND CHAMBER OF COMMERCE, ACCOMPANIED BY DOM RAINO, COMMISSIONER, MARYLAND HEALTH RESOURCE PLANNING COMMISSION; RICHARD J. DAVIDSON, PRESIDENT, MARYLAND HOSPITAL ASSOCIATION; AND PETER J. LOMBARDI, EXECUTIVE DIRECTOR, MARYLAND CHAMBER OF COMMERCE

Mr. KELLY. Let me first thank you very much for the opportunity to be here this morning. Joining me in our testimony and statement today are Peter J. Lombardi. He is the executive or the president of the Maryland Chamber of Commerce; Richard J. Davidson, president of the Maryland Hospital Association; and Dom Raino, commissioner of the Maryland Health Resource Planning Commission.

Again, thank you very much for the opportunity to appear before you this morning. You do have written copies of our testimony, which is three pages. And I will try to zip through that as best I can in the interest of time.

My name is Winfield M. Kelly. I am a Prince Georges County businessman, former elected official, and a hospital trustee. I am here today as a director and representative of the Maryland Chamber of Commerce and, with the individuals here with me, part of a coalition of organizations in our state who believe that superb medical care for Maryland veterans can be delivered without construction of the proposed $110 million Veterans' Administration replacement hospital in downtown Baltimore.

Although as civic and business leaders we appreciate all of the advantages of a major Federal construction project in our State—$121 million we hear—we are convinced that in an era in which Federal spending must be curtailed, new and innovative ways must be found to meet our commitment to America's veterans.

And let me be clear. First-rate care for veterans must be and is our No. 1 priority. We are well aware, too, that the Veterans' Administration is faced with a growing demand for long-term care and continuing responsibilities in psychiatric and rehabilitative care.

If good health services for our deserving veterans genuinely is the Federal Government's goal, does it not make sense to use all of the best resources available to their fullest extent? Maryland has 54 community acute care hospitals, 26 of them in the Baltimore area. We have perhaps the Nation's most sophisticated system of regional trauma centers and teaching facilities. Our State's hospitals include the University of Maryland medical system with which the new Baltimore VA facility would be affiliated.

Maryland hospitals, like community institutions in every State, have witnessed dramatic changes over the past several years. For a variety of reasons, inpatient hospital utilization is falling. More care is being provided on an outpatient basis, resulting in fewer admissions. Payment policies and new technologies have combined to cause the average length of a patient's stay to decrease.

In short, new capacity is available in community institutions where it did not exist before. The post-World War II era pressure to build both community and VA acute care facilities to serve a growing population in fact has disappeared.

The coalition of business, labor, health care providers, and State health regulators before you today believe the time and conditions are right to try a new pro-veteran alternative to the construction of an expensive new VA hospital in Baltimore—a building that is, today, years away from admitting its first patient. The new facility we believe simply is not needed.

When excellent facilities stand ready to serve and when we must keep a close rein on our resources, we owe it to our veterans to ensure for them the best care—wherever it is available, as soon as possible.

We would urge your committee, the Congress, and the administration to give serious consideration to an experiment in Maryland. We would support the creation of a Veteran's Key Card Program for a trial period of 3 to 5 years. During that time, any Maryland veteran eligible for and needing health care could get that care at the hospital of his or her choice. Rather than journey to Baltimore or into Washington, the Maryland veteran on the Eastern Shore or western Maryland could receive care in his or her own community.

In the Baltimore area, University Hospital, with which a new VA facility would be affiliated, as I have indicated earlier, ought to be the focus of the experiment. At the end of 1985, university was operating at about 62 percent of its licensed 785-bed capacity. That means approximately 300 beds would be available.

I could not help but note that the VA Administration is using private nursing homes throughout the country, evidently quite successfully now.

Maryland hospitals are tightly regulated by our Health Services Cost Review Commission. Thus, for the period of the experiment the costs of treating patients could be closely monitored and regulated. Also note that the cost of an average stay at a Maryland hospital is slightly below the national average. Moreover, we have a sophisticated system which is in place to oversee and ensure the quality of care.

During the experiment, the VA could move forward with its plans to upgrade and refocus the missions of its three other Baltimore area facilities. If, at the experiment's conclusion, the need for a new acute care hospital is demonstrated, it is likely the Nation will be better able to afford the cost if the crushing deficit is under firm control.

Meanwhile, an important public policy question would have been addressed. And it is our sincere belief that such an experiment would prove successful and thus become and important and valuable new part of the VA health system.

What we are suggesting is not new. It has been proposed before in other forms. Organizations in Maryland have been backing such a test since the late 1970's, but it is hard to assemble support for reasons I am sure do not need to be explained to you and members of the committee.

Times are different. The American health care system is undergoing dramatic change. The Federal Government is under unprecedented fiscal pressure. New challenges confront the Veterans 'Administration. Here is an opportunity to ensure that veterans have access to the best care available, regardless of the future, by employing resources already on line, already delivering care.

As a matter of fact, in the Palm Beach area of Florida, a similar controversy is at hand over the construction of a new hospital there. Congressman Mica and his colleague, Congressman Lewis, are supporting an experiment there by way of contracting with community hospitals for some veterans care. It must be worthy and is worthy of a try.

We urge you to encourage the experiment we propose in Maryland. It offers the potential for everyone to come up a winner—veterans, the community, the University of Maryland medical system, the Federal Government, and our taxpayers.

Thank you. We would be happy to respond to any questions you may have and offer additional comments by perhaps Dick Davidson or Pete Lombardi.

[The prepared statement of Mr. Kelly appears on p. 153.]

Mr. **Davidson**. Mr. Chairman, we would like to note that historically we have offered the idea of the key card approach without much success in terms of anyone seriously entertaining the idea—except individual veterans. We have not been able to interest our own congressional delegation at this point.

But we, in our conversations with veterans around the State—not necessarily veterans' organizations—have found a distinct interest in that proposal.

Now, earlier in the hearings today I think it was very significant that some of the questions raised of the VA witnesses delved into this question: Are there any private sector alternatives to the Baltimore Hospital? And that examination has not taken place for some time.

I would only want to suggest that should that examination be taking place over the next 60 days that it include not only the consideration of the key card concept but it consider other kinds of options, one of course of which is to buy an existing facility if one were available. Another option would be to lease a facility or to lease parts of a facility.

Because of the declining use of acute care hospitals there are obviously lots of opportunities for some of those things to place.

But I sense that one of the major considerations may just be the buying option. And it would seem to us that there are a lot of other options that ought to be considered if in fact there is going to be an innovative approach to dealing with the issue.

Mr. PRINCIPI. Have you discussed the issues of leasing, purchasing existing facilities, or the key card systems with the VA? Have there been any discussions, formal discussions on these matters?

Mr. DAVIDSON. We met with then Medical Director Don Custis in 1984 to discuss the matter. We had a long conversation—at least trying to present our point of view about the contradictions in public policy with regard to excess hospital beds and this particular idea. While there was some sympathy toward the concept of the idea, there is belief that there was not really support for it.

The major reasons given were two:

The Veterans' Administration, No. 1, under a key card approach, would not be able to control the costs of such a program, and; second, that there was such a close alignment to medical education that it was crucial to build the new Veterans' Hospital in direct cooperation with the University of Maryland.

Now, this is 1986. The question of controlling costs has never been pursued. So no negotiations have ever really taken place. As I mentioned earlier, no one has ever taken these proposals very seriously, at least from all of us who have offered them.

Mr. PRINCIPI. I only have one additional question.

Your idea of a veterans key card system may raise concerns of some, I would suspect many, who fear that the VA hospital system may eventually be dissolved if veterans were to be mainstreamed in to the private sector to receive their health care. How would you respond to this view, which is held very strongly by Members of Congress and by the service organizations. They believe in the importance of maintaining a viable and strong VA health-care system, not only to care for veterans but to serve as a backup, a contingency hospital care system in the event of mobilization or war?

Mr. KELLY. I think there is a clear demonstrated need for such a system. It certainly has served the veterans well over the past decade.

Clearly there are instances where that system should continue. But to have the key card choice in the particular area, regional catchment area you are talking about, gives an opportunity for veterans to get the quality of care that exists at a hospital of their choice. So we do not see that disrupts the full system. Rather, it utilizes, as they themselves are utilizing one of their floors, I guess, they are leasing one of their floors to the Air Force in one of the States now in a unique way to begin full utilization of a facility. We think that is appropriate and proper.

Dick has a further history of that. Perhaps he would want to comment, or Dom Raino from our planning agency.

Mr. PRINCIPI. How many empty hospital beds are there in the Maryland area?

Mr. KELLY. More than 5,000—the number is debatable.

I will tell you that through the State Planning Agency, and Dom Raino is here, a ratcheting down process has in fact occurred. At least recently, the State agency just adopted through the legislature a ratcheting plan to prioritize the list of excess hospital beds and to compel hospital bed reductions at a number of our institutions.

Mr. DAVIDSON. Within the Baltimore area itself there are approximately 2,000 beds that could be available on any given day.

Before we proceed I would like to respond to that important question that you asked, because I think it is a very legitimate one. It is the concern that veterans have that an experiment such as we are talking about—a key card approach—could lead to the dismantling of the veterans' medical system. And again, I think that is a very legitimate concern.

It seems to me that what we are proposing is an alternative to the continued construction of acute care facilities. Evidence was presented today that there is a diminishing need for those kinds of services, but more importantly, that you experiment with delivery. If you look at the Baltimore area itself, you heard evidence today that the Loch Raven facility is rapidly deteriorating. Yet, we are talking about the building of a new facility that is many years from completion.

Our proposal only calls for an experiment for a given period of time to see if in fact this idea works, to see if it makes sense in terms of the cost containment objectives, to see if it makes sense in terms of satisfaction for our veterans who deserve good care. It would have to be evaluated. It may not be the answer and it may not be the direction that the Government wants to go long term, but it ought to be tested. In the absence of an experiment I do not know how we can dismiss it as a viable idea—one that does not in fact threaten the future of the veterans' system.

Mr. RAINO. Could I respond to that as well. The commission that I serve on has responsibility for administering the certificate need law in Maryland. And one of the criteria on which we evaluate any proposals is what will this do to improve the access of care to the general population?

I believe this key card proposal, rather than be looked at as a potential replacement for the VA system, should be viewed as an enhancement to the existing system where it gives the veteran some choices and can receive appropriate care closer to home and improve the access to care for the veterans.

Mr. KELLY. Let me also add, and I did not, that the Maryland Association of Counties, the Maryland Health Care Coalition, and Labor and Management Coalition in our state come together and join us in this testimony and did plan to be here today but unfortunately could not.

Mr. PRINCIPI. Well, I thank you, gentlemen.

Again, I apologize for the chairman's absence. I hope you recognize the difficulties of various votes in different committees, but certainly he will consider your testimony. We will have additional questions for the record.

[The questions and responses appear on p. 359.]

I thank you very, very much for your testimony this morning.

Mr. **Kelly**. Thank you very much.

Mr. **Principi**. Yes.

At this time we will have the final panel which consists of representatives of the service organizations. I apologize to them for the long delay.

Good morning, gentlemen. Mr. Egan, you may begin.

STATEMENT OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION, ACCOMPANIED BY RODNEY S. KIRK, ASSISTANT DIRECTOR, NATIONAL VETERANS' AFFAIRS AND REHABILITATION COMMISSION

Mr. **Egan**. Thank you. I have with me today Rod Kirk who is the assistant director of our Veterans' Affairs and Rehabilitation Commission.

I will summarize our remarks. And we are both available to answer any questions that you might have.

First of all, we would like to concur with the chairman's statement that with regard to the reorganization of the Office of Construction that VA seems to have gone about the business of reorganization before they have gone about the business of reforming the process. We think that may be putting the cart before the horse, and that VA should certainly proceed with the reform of the process.

Apart from that, Mr. Chairman, your letter of invitation to testify at today's hearing asked for some discussion of VA health planning policy. Under the circumstances, the extent to which VA planning is undertaken is inseparably tied to the authority given it by the Congress and to the fiscal limitations imposed by the Congress and OMB. Added to this is a seemingly natural tendency in any bureaucratic agency to view planning from a parochial standpoint of the specific programs administered.

These fiscal limitations and bureaucratic tendencies often work counter to the desirability of establishing unified overall national policies to which individual Federal agencies, including the VA, can contribute substantially.

The subject of health planning for a rapidly growing population of aging citizens is no exception. The VA should be able to make a major contribution to whatever national policy is adopted.

Unfortunately, there is no current overall national policy even though the consequences of failure to adopt one will be enormously costly in both human and fiscal terms.

What is currently masquerading as national policy are no more than a series of cost containment initiatives designed to restrict rather than augment existing health care delivery and health funding systems. One example in VA is the administration's plan for the future that dictates no new nursing home construction and greater reliance on private sector community nursing homes.

The nursing care formula currently in use consists of 40 percent VA, 40 percent State homes and 20 percent private sector. The new plan calls for 30 percent VA, 40 percent State homes and 30 percent private sector. This unilateral change in focus ignores the fact that the private sector is ill-equipped to handle the demands in the 1990's.

While the administration's budget proposed to increase funding for State homes by 100 percent over fiscal year 1986, this is only a real increase of 5.9 million over fiscal year 1985. Again, this new policy bears no relationship to the resources needed.

Given the fact that the number of veterans over 65 will increase from the current 3.5 million to 9 million by 1990, and that two out of three, two out of every three male citizens in the year 2000 will be veterans, this initiative cannot realistically be called health-care planning. This is especially evident given VA's existing facilities.

In 1984, 17,187 veterans with an average age of 70.3 years were treated in VA nursing homes. The same year, State homes had an average daily census of 7,467, nursing homes; 4,401, domiciliary; and 514 hospital patients. Unless something is done, this will be grossly inadequate in the years ahead.

In the private sector, HHS estimates that the population of nursing home residents could increase by 54 percent by the year 2000. And with only 19,000 nursing homes supplying 1.4 million beds at the present time, it is estimated that an additional 1.2 million beds will be needed by the year 2000.

Given the fact that 54 percent of all nursing home care in the private sector is paid for by public funds, unless a genuine national policy is adopted the cost to the Federal Government can be expected to skyrocket.

In human terms, 2 out of every 3 nursing home residents are dependent not on Medicare but on Medicaid. To establish eligibility for Medicaid, 40 percent of elderly individuals 75 years of age or older and 60 percent of those 66 or older will spend down to poverty levels after just 13 weeks of nursing home care.

Both veterans and nonveterans alike deserve better than this. Already, 40 percent of total Medicaid spending is devoted to nursing home expenditures. Moreover, most citizens do not realize that Medicare pays only 2 percent of the total cost of all nursing home care provided in this country and that private insurance to cover nursing home care is nearly nonexistent.

What is needed is a unified, multifaceted, national policy approach to provision of health care for the aging. Anything less ignores the clear need to make meaningful long-term planning choices. In order to provide the VA with the planning authority and budgetary resources needed to address the problem of an aging veteran population this committee needs to explore the possible health-care options for both veterans who will use the VA as well as those who will not.

It is clear the VA's resources are inadequate and more will have to be added. However, since most veterans treated by VA are and will continue to be service disabled or poor, this committee needs to direct more of its attention to the fate that will befall the vast majority of veterans in the private sector. In doing so, a closer and more coordinated relationship between this committee and several other committees that share policymaking responsibility for health-care planning must be established.

At least two other committees immediately come to mind, and those include the Special Committee on Aging and the Finance Committee.

For its part, VA should actively consult with other agencies sharing responsibility for administration of health care for the aging.

That concludes our summary.

[The prepared statement of Mr. Egan and Mr. Kirk appears on p. 156.]

Mr. PRINCIPI. Mr. Cullinan.

STATEMENT OF DENNIS M. CULLINAN, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. CULLINAN. Thank you for this opportunity to present the view of the Veterans of Foreign Wars with respect to issues pertaining to the Veterans' Administration's medical facility construction. The VFW is very alarmed at the administration's proposed construction budget for the VA's Department of Medicine and Surgery for fiscal year 1987 of only $408 million in new budget authority. This is a reduction of over $208 million from fiscal year 1986, and clearly demonstrates the administration is willing to forsake the Nation's moral commitment to provide high-quality health care to veterans now that demand is on the rise.

Considering that the health care needs of the aging veteran population will continue to increase and place an ever greater demand on the VA's delivery system, the administration's proposed reductions in the VA's medical care construction authorization would serve to exacerbate a situation which is already critical.

The proposed authorization for fiscal year 1987 for the replacement and modernization activity is only about $212 million. This is a reduction of over $189 million from fiscal year 1986 and would mean that the VA could not maintain even its current physical structures.

Further, the administration is proposing reducing the authorization for VA nursing home construction from $22.5 million to only $4 million in fiscal year 1987. This paltry funding level will result in all new VA nursing home projects being canceled.

Similarly, it may only be viewed as appalling that no new funding is to be provided for fiscal year 1987 for VA domiciliaries.

The VFW applauds the proposed increase of over $21 million in budget authority for grants for construction of State extended care facilities which would set the authority for this program in fiscal year 1987 at over $42 million. Properly utilized, this should assist the VA in reducing the number of backlogged applications on hand from the States and should result in more extended care beds being available sooner.

We would point with alarm at the proposed diminishment of the VA's major construction activities funding along with the proposed reduction of over $24 million in its minor projects authorization. In sum, such a low level of funding would constitute a severe blow to the VA's health-care system.

We would now focus on the proposal to reorganize the VA's construction planning process and organizational structure. This plan encompasses transferring the Office of Construction to the Department of Medicine and Surgery resulting in the Chief Medical Director having full accountability and responsibility for the agency's construction program. A new Office of Facility will be created by combining existing resources, staff, and functions of the Office of Construction and DM&S's facility engineering, planning and construction office.

We support bringing the VA construction program directly under the Chief Medical Director's control so long as certain concerns are met. For one, we are apprehensive that the Department of Medicine and Surgery will run into problems by having to manage not only its own construction program, but also those of the Department of Veterans' Benefits and the Department of Memorial Affairs.

A fundamental concern is with the method in which the proposed reorganization is to be implemented. The Booz, Allen and Hamilton report clearly states that first the current level of integration between the construction program and the health care program must be made in two general areas: One, construction policies and procedures are needed that provide greater consistency with those of the health care program and, two, organizational functional alignments are needed that reduce coordination requirements between the two processes.

It certainly makes sense to us that the implementation of process reform comes before structural reorganization. We fear that not enough effort is being invested in discerning and implementing critical process changes and that too much emphasis has been placed on changing the organizational structure. In other words, it is essential to first determine what the Department of Medicine and Surgery's construction budget goals are and how they are to be achieved before deciding who should go about doing it.

Careful and consistent planning will be essential in designing an effective overall VA construction strategy. In this regard, the Booz, Allen and Hamilton report points at a direct involvement between medical district initiated program planning and individual VA medical center facility construction needs. It is our understanding that at this time the VA construction planning process, including long-range strategic planning is both inconsistent and ineffective.

This means that adequate assessment of proposed medical facility mission changes and the utilization of means of purchasing or leasing already existing private sector facilities is virtually impossible. Thus, the VFW may only comment on these means of providing health care to veterans on a case-by-case basis.

The VFW views the delegation of VA construction projects to individual VA medical center directors as being an inadequate means of addressing the shortcoming of the current construction planning system. In short, this is not so much an attempt at a solution as at a quick fix. It most certainly does not present the comprehensive solution to the planning, design and construction problems recommended by Booz, Allen and Hamilton.

In concurrence with this study, the VFW is convinced that the VA Central Office must maintain primary responsibility in planning, designing, and construction processes in order to ensure consistency of care at all VA medical centers.

With respect to Gramm-Rudman-Hollings, it is our opinion that the entire VA, including its construction program, should be exempt from reductions pursuant to sequestration. It is very apparent that the VA construction program has done its share and is already strained to the limit and cannot successfully tolerate any further cutting.

In light of the fact that it has been estimated that the next sequestration order may be as high as 30 percent, we view it as essential to exempt the VA construction program.

Regarding the VA and the Department of Defense sharing medical care resources, the VFW believes that such arrangements may well benefit both the Veterans' Administration and the military. We will be closely watching the pilot project between the Air Force and the VA in Albuquerque, NM. Hopefully, this course of action will serve to provide those special services not usually found in either Air Force or VA facilities by themselves.

With respect to S. 2141, the VFW holds that if the land cited in that particular measure were to be sold, that the VA would be deprived of the necessary latitude for expansion in the future. Also, it is our understanding that the land in question at the Veterans' Administration Medical Center located in west Los Angeles is not free and clear and that costly litigation could ensue if the VA were to attempt to sell this property.

We are also opposed to the selling of the 46 acres of land at the VAMC in Sepulveda, CA.

Thank you. That concludes my statement.

Mr. PRINCIPI. Thank you, Mr. Cullinan.

Mr. Gorman.

[The prepared statement of Mr. Cullinan appears on p. 174.]

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you, Mr. Principi.

I would also like to say it is indeed a pleasure for me to be here and appearing before the committee this morning to discuss the VA's construction budget and various policies in the construction program.

I think from our first viewing of the fiscal year 1987 budget proposal it was quite clear that it was totally inadequate to meet the needs of the system in the future and the demands that are and will be placed upon the VA medical care system. I would like to take this opportunity, though, to commend the entire committee for their actions that recommended restoration of approximately $35 million to the fiscal year 1987 construction budget. We certainly appreciate that action.

Also, it is clear that there is a shift of the VA's policy as far as long-term care, also indicated by the 1987 budget submission, that being, specifically, no new construction funds being requested for construction of nursing home facilities. We believe that the administration is being extremely shortsighted in proposing such a policy and in trying to shift the care of long-term care patients into the private sector, primarily because we are unaware of any kind of verifiable statistics to show the private sector will be in the out years capable of providing the kind and scope of long-term care that will be needed.

There was talk this morning of some proposed mission changes to certain VA facilities and conversion of some acute care beds into long-term care beds. The DAV in every instance would not oppose certain proposed mission changes. However, I think there has got to be kept an appropriate balance, depending upon the medical facility affected, for a balance of acute care needs to the long-term care needs upon that particular facility.

I think also that construction funds can be very wisely used by the putting of construction funds into those acute care beds that have been closed down or are to be closed down and apply the conversion principle to that.

The DAV supports the request for the advanced planning fund and also the proposed $19 million for the design fund for fiscal year 1987.

Also, as far as the issues that you asked for our discussion on in the letter of invitation to testify, I think our written statement more or less goes into some detail regarding those. We do support the concept of VA and DOD sharing agreements. We think it is an innovative step. Also, it is going to be good for the veteran and the taxpayer in the long run.

Specifically referring to the VA and DOD agreement in Albuquerque, we would only make one cautionary note to the VA, and that is in the providing of hospital services to military personnel and other eligible beneficiaries that no veteran that seeks care at that facility would be displaced from care or be denied or postponed care.

As far as the concept of reorganization, again we support that. We think the bottom line in such a reorganization of the Office of Construction would be to streamline the agency, with the appropriate planning and accountability levels placed where they do belong. Again, we support the concept.

With reference to MEDIPP, I would make a comment also in the same vein with the delegation of construction projects. That is, it seems the biggest benefit that has been voiced by the individual medical facility directors who have had nursing home projects delegated is their pleasure at the final outcome of the project. I think that says something has to be done to get the medical facilities directly involved from the conceptualization of the idea through the process of the finished product.

The other remaining issue I would like to discuss is that of S. 2141. The DAV does support S. 2141. And we thank Senator Cranston for the introduction of that legislation.

That concludes my summary, Mr. Principi.

Mr. PRINCIPI. Thank you.

Colonel.

[The prepared statement of Mr. Gorman appears on p. 184.]

STATEMENT OF DAVID J. PASSAMANECK, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. PASSAMANECK. Thank you.

Mr. Chairman, AMVETS is pleased to address the proposed fiscal year 1987 plans for the Veterans' Administration medical construction.

I would request that my printed statement be included in the record. I will attempt to condense it at this point.

Mr. PRINCIPI. It will be so included.

Mr. PASSAMANECK. Thank you.

We oppose, let me say at the outset, the enactment of S. 2141 as unnecessary congressional micromanagement. We agree with Senator Cranston that the call on this issue is the Administrator's, and we would like to leave the decision in his capable hands.

Regarding cooperation between the VA and the military medical system, let me say that we definitely look with favor upon cooperation, maximum cooperation between those two systems. However, we would like to caution that, as one of my colleagues just mentioned here, that veterans not be frozen out of care that they otherwise would get in the VA system.

And I would like to go one step further and point out the fact that we would like to see the day come when retired military, who are in many cases being turned away from military hospitals, would have the right to get the care to which they are entitled in VA hospitals. In other words, I would like to see that if the system is integrated, why not do it both ways, take care of the military community, retired and active, in the total system and the same thing for the veterans. I would like to see veterans be able to go to Walter Reed and get treatment if necessary. Not necessarily Walter Reed. We have those things here in Washington. But in some other location where it might be geographically advantageous.

In the fiscal 1987 VA budget overall construction will be cut some $332 million over and above the 1986 Gramm-Rudman cuts of some $21.8 million, resulting in the cancellation of seven previously planned nursing homes.

Mr. Chairman, as we look at medical construction we all agree that many VA facilities are aged and in need of replacement or modernization. Focus needs to be centered on all construction projects present and future. How can or will the VA respond to a veteran population which places greater annual demands on the VA for medical care? What conclusions can be drawn when the construction account is proposed at $408 million, down $368 million since fiscal year 1985? What will become of major and minor construction projects? How is the VA planning for the aging veterans and their related medical problems?

A fresh coat of paint hides little and does little. The replacement and modernization account is down $188.8 million, with nursing home care down an astounding $18.4 million to $4 million. Even domiciliaries is down $22.9 million, with no appropriation request for fiscal year 1987.

One possible bright spot in the medical account may be the grants for construction of State-extended care facilities proposed at $42.4 million, up $21.5 million over fiscal year 1986. Twenty million dollars may build a lot of State veteran nursing homes which will of course relieve the VA of finding space for veterans in its system. We are, therefore, not surprised that there is a dramatic upturn of funds in this account.

The DM&S budget seeks a massive shift of nursing home care to State and community—for emphasis read "private"—nursing homes, even though such facilities are not available in many areas of the country. The adoption of this budget will set the entire VA medical delivery system on a rapid course to extinction, thus destroying what over 55 years of heartbreaking struggle has built into a living monument to the pride and gratitude of a free people for the sacrifices of those who shouldered arms in the defense of the Nation.

Thank you.

[The prepared statement of Mr. Passamaneck appears on p 204.]

Chairman MURKOWSKI [presiding]. Thank you, Colonel.

I do not know whether I can agree with your general conclusion. In fact, I would take issue with it. But you are certainly entitled to express your opinion. That is the point of the hearing.

But to suggest that it is the purpose of this chairman to reduce or disintegrate the VA health system is certainly a misreading. We must deal with the reality that we are never going to have as much as we want, we had better damn well do effectively with what we have.

Mr. PASSAMANECK. I am sorry.

Chairman MURKOWSKI. Of course, your responsibility obviously is to provide as much as possible for the veterans that we have a charge to provide for. So I just want to make sure we both understand one another.

Mr. PASSAMANECK. Let me say one thing, sir. I am referring to the administration's budget, I was not referring to the chairman of this committee.

Chairman MURKOWSKI. I understand.

Mr. Moran, please proceed.

STATEMENT OF BOB MORAN, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA, ACCOMPANIED BY KIM BEASLEY, ASSOCIATE NATIONAL SERVICE DIRECTOR

Mr. MORAN. Thank you. Thank you, Mr. Chairman and Mr. Principi.

I would like to mention that I am accompanied by Mr. Kim Beasley, Associate National Service Director, today. I will summarize from our written testimony. And I would like to briefly address what we feel are the three most critical construction issues cited in the invitation to testify.

VA medical facility construction authorization requests for fiscal year 1987.

While we thank this committee for the restoration of construction dollars to the administration's original fiscal year 1987 budget proposal, it is difficult to comment on the adequacy of the VA's construction authorization request for one simple reason: The VA currently does not have a comprehensive assessment of construction needs.

The comprehensive study of the VA's organizational and procedures for construction of health care facilities completed 1 year ago by Booz, Allen & Hamilton reveals the following:

Initial descriptions of project scope developed by VAMC's do not provide an adequate basis for undertaking program and project planning activities;

The current approach to prioritizing construction projects does not provide an adequate basis for resource allocation decisions;

There is no clearly defined national strategy or plan for meeting the combined construction needs of 172 VAMC's.

Based on the findings of the study that the VA's annual 5-year medical facility construction needs assessment is not an assessment of need but rather an executive summary of major construction projects requested by 172 individual medical centers through their 5-year medical facility plan.

If individual 5-year plans are as fundamentally flawed as the Booz, Allen study indicates, then the VA's construction authorization request has little or no basis. The VA's new prioritization methodology simply prioritizes construction requests, not necessarily overall construction needs.

The intent of the directive contained in Senate Report 98-506, was to structure a priority order whereby projects that will correct the most serious deficiencies will be developed first. We contend that the new prioritization methodology fails to fulfill that intent because no mechanism currently exists whereby the relative comparison can be established.

Now that the Booz, Allen & Hamilton study has identified the inadequacies of this planning methodology, this public law is, in fact, unfulfilled.

No. 2, proposal for reorganization of VA construction planning process and organizational structure.

In a letter to PVA's executive director, former VA Administrator Walters indicated that it would be advantageous to designate concurrently a single point of accountability for the agency's construction program. He stated that discussions with Booz, Allen & Hamilton principals, veterans' service organizations, and congressional staff "have confirmed that a major organizational realignment is a prerequisite to an improved agency construction program." PVA agrees with that position.

Nevertheless, the proposed reorganization currently being considered fails to acknowledge the impact of the procedural changes necessary to improve the construction program. It is important to note that the Booz, Allen study recommendations are two-part: process recommendations and organizational recommendations. It is not coincidental that core process recommendations precede organizational recommendations. There is an inherent danger in implementing a detailed reorganization plan around a seriously flawed process.

The core process recommendations which correct the serious procedural flaws should, in fact, be the basis of the proposed reorganization. It is clear that reorganization alone will not correct the problems cited.

One painful example of the current system's inability to perform effectively is evidenced in the VA's proposed nursing home prototype. The VA inspector general in a report stated: "The VA has not yet accomplished its major program initiative of developing a nursing home—unit prototype * * *"

The reports conclusion stated that in the opinion of DM&S and officer of construction representatives, the planned reorganization of these two organizations "will correct organizational issues leading to problems surfaced in this review."

The inspector general, however, stated that the planned reorganization will not ensure resolution of the issues relating to the nursing home prototype. The inspector general's recommendation was the VA should establish an appropriate design and approval process for assuring a cost-effective design of prototype nursing homes.

It is our concern that too much emphasis is being placed on organizational structure and not enough emphasis given to crucial process changes.

It is imperative that the proper implementation of the core process recommendations be assured.

In reference to MEDIPP, the implementation of Booz, Allen study recommendation should strengthen the program. Properly implemented, the same recommendation should fulfill the intent of the current strategic planning effort. The VA should be in a better position to measure the impact of mission changes, leasing or purchasing private sector facilities if a proper needs assessment of the total system can be determined.

In reference to delegation of VA construction projects to VA medical center directors, it is easy to empathize with VAMC's who, over the course of recent years, have become dissatisfied with a construction planning system that grew less and less responsive to their needs. The process is lengthy, cumbersome, ineffective or inefficient in providing capital improvements to their physical plants. They are often left out of key areas of project development.

It is unfortunate that delegation is seen by some as a solution to these problems. It should be noted that the idea of delegation is in direct conflict with the Booz, Allen, Hamilton recommendations. In contrast, the Booz, Allen study includes a comprehensive analysis of the current system and clearly defines procedural and organizational problems. This became the basis for recommending a comprehensive solution to the planning, design and construction problems.

Finally, Mr. Chairman, I will address very briefly two specific points of concern to PVA, which are the impact of Gramm-Rudman on VA construction projects.

A 4.3 reduction or, for that matter, almost any reduction is nullified by A/E design change fees and most likely change orders in the fields. This is particularly true and has a significant impact on construction projects that are in the late stages of design or working drawings, not to mention those already under construction.

And last, in reference to options for providing parking at VAMC's.

A reduction in beneficiary travel, coupled with inadequate parking facilities, places a significant hardship on many veterans. This is compounded by the fact in the case of serious disabled veterans by the inadequacy or lack of accessible public mass transportation.

Parking also has implications for the well-being of the veteran in that the presence of family members play a crucial role in the recovery and rehabilitation of veteran patients.

This concludes my statement. And either myself or Mr. Beasley will be glad to answer any questions you might have. Thank you.

[The prepared statement of Mr. Moran appears on p. 214.]

Mr. PRINCIPI. I have one question that I would like to propound to the service organizations with regard to your point, Mr. Moran, about parking.

I think it is clear to the committee that parking is an integral part of any VA medical care system. Second, that the current situation is totally unsatisfactory, especially in places such as San Francisco; Syracuse, NY; and Durham, NC.

And third, I think it is a fact that we are not going to get much relief in the way of appropriations, due, in part, to the Appropriations Committees.

Would you support the concept of paid parking, if we could get the Appropriations Committees to channel an initial appropriation into a revolving fund of $20 or $30 million, with the stipulation that VAMC's could draw money out of that revolving fund if they would establish a paid parking concept that first, was reasonable, second, applied only to new parking facilities or modernization of new facilities, and third, would not extend to any of the veteran patients?

Would the service organizations support a paid policy concept for employees and visitors at those new parking facilities?

Mr. Egan.

Mr. EGAN. We would probably support that. But I would caution in just one area. We heard VA talk about the need or desirability of having a uniform policy so that everybody systemwide pays for parking. There are some areas of the country, some specific VAMC's where parking is not a problem. And it would not necessarily be wise decisionmaking to require that parking be paid for at those facilities.

Now, in metropolitan areas where other hospitals in the same general metropolitan area have situations where employees pay for parking, it would seem, in the interest of comparability, suitable. But——

Mr. PRINCIPI. It would only apply to new parking structures or new parking lots which the VA may acquire, build, or otherwise contain. It would not apply to any VAMC which currently has adequate parking, only to new ones who have to draw money out of the revolving fund. They would be required over a 20- or 30-year period to amortize the costs of that construction and pay back into the revolving fund so that we would have an ongoing fund to provide parking facilities.

Mr. EGAN. We have no problem with the principle.

Mr. PRINCIPI. Thank you.

Mr. Cullinan.

Mr. CULLINAN. Just answering off the cuff, so long as veterans were not in any way penalized. In other words, they did not somehow wind up being precluded from parking in or about VAMC's through implementing such a process, I do not believe we would oppose it.

Mr. PRINCIPI. Mr. Gorman.

Mr. GORMAN. We would support that in principle.

Mr. PRINCIPI. Colonel.

Mr. PASSAMANECK. We not only would support it, but we would agree with the chairman that the authority as far as we can see is already there. And we cannot understand why they have not used it.

Mr. PRINCIPI. Mr. Moran.

Mr. MORAN. If the chairman would allow us, I think we would rather respond in writing at this time. It is hard enough to retain quality health care individuals. And I understand under new parking facilities for employees, I am correct, I would hesitate to give you an answer at this date, but I would respond in writing.

Mr. PRINCIPI. Thank you.

The facilities would be for employees and visitors. Of course, no one would be required to park in that facility. We have additional questions which we will submit in writing for the record.

Mr. MORAN. I understand.

Mr. PRINCIPI. Thank you.

[The questions and responses appear on p. 362.]

Chairman MURKOWSKI. Thank you, Tony.

I would like to thank the panel representing the veterans' organizations. I would like to particularly acknowledge General Turnage, who just walked out. But he has seen fit to sit through the entire session this morning, some 3 hours. I think that is indicative of his interest in hearing the views of those that are here today.

I wish you all a good day and look forward to the next time when we will meet again. In addition, those of you who follow the hearings know that we are pursuing some other areas of examination, particularly the comparison of the private sector costs vis-a-vis the Federal sector VA costs per bed. I think that will be interesting to pursue.

Thank you, gentlemen and ladies.

[Whereupon, at 12:47 a.m., the committee was adjourned.]

APPENDIX

April 10, 1986

SENATE COMMITTEE ON VETERANS AFFAIRS
HEARING ON
VA CONSTRUCTION

Honorable Jeremiah Denton, U.S.S.

Mr. Chairman, I join with you in welcoming our witnesses. VA construction is an important subject, and I am pleased that the VA, GAO, Maryland State Officials, and the veterans service organizations are prepared to give us their testimony.

I would also like to welcome General Turnage to his first hearing before the Committee in his capacity as Administrator. The newness of his tenure may indeed be an asset in this instance, because it will allow him the opportunity to take a fresh look upon the manner in which the VA approaches hospital construction.

During the last two years, this Committee has made several suggestions to the VA on ways to improve the efficiency and method of acquiring hospital beds for its veterans.

We suggested that the VA use standardized construction methods for its hospitals in such areas as nursing stations, cafeterias, operating rooms, and power plants, to name a few. We also recommended that the VA should look into sharing or leasing existing private sector facilities as a supplement to their own. Obviously, there are many options that the VA can and should pursue in an effort to provide increased and efficient care of its veterans.

If the VA is to continue to provide the same quality of care for our veterans, it must find less expensive and more cost-effective ways of acquiring hospital and nursing home facilities. One of the most important options is the aquisition of suitable existing facilities rather than building new ones at great cost. The budget crunch is going to get worse, not better. Therefore, I would rather ensure that there is adequate care for our veterans in adequate facilities, particularly if the alternative is care provided in lesser amounts to fewer veterans in a smaller number of high cost facilities.

The number of veterans over age 65 is projected to increase to three times the current level by the next century. That situation will put a strain on the VA system as it currently exists and as it is projected to exist. For

VARIOUS REASONS, THE COST TO CONSTRUCT A NEW VA MEDICAL FACILITY IS AT LEAST TWICE THAT OF THE PRIVATE SECTOR, AND IT TAKES MUCH LONGER. TO ME, THAT SITUATION IS INEXCUSABLE, NOT ONLY BECAUSE IT MAY WELL BE A WASTE OF MONEY BUT BECAUSE IT DEPRIVES OUR VETERANS OF THE CARE THAT THEY NEED AND DESERVE.

THE VETERANS ADMINISTRATION MUST CONSIDER THE LEASE OR PURCHASE OF EXISTING MEDICAL FACILITIES BEFORE DEVELOPING PLANS FOR NEW ONES, WHETHER AS REPLACEMENTS OR AS ADDITIONS TO THE SYSTEM. THE VA ALREADY ALREADY HAS THE LEGAL AUTHORITY TO LOOK AT LEASE OR PURCHASE, BUT IT DOES NOT NOW DO SO AND IS RELUCTANT TO BEGIN. DURING THESE TIMES OF BUDGET CONSTRAINT, I DO NOT BELIEVE THAT THE VA, OR THE CONGRESS, CAN AFFORD TO PAY FOR THE CONSTRUCTION OF OVERSIZED, GLAMOROUS HOSPITALS AT THE EXPENSE OF OTHER VITAL VETERANS SERVICES.

LAST YEAR, DURING THIS COMMITTEE'S CONSTRUCTION HEARINGS, I TESTIFIED EXTENSIVELY ON THE SUBJECT OF ACQUIRING EXISTING HOSPITAL FACILITIES, AND GAVE THE SPECIFIC EXAMPLE OF PROVIDENCE HOSPITAL IN MOBILE, ALABAMA. MY REMARKS ARE ON RECORD WITH THIS COMMITTEE, SO I SHALL NOT BELABOR THE POINT. MOREOVER, I HAVE A PERSONAL ASSURANCE

FROM THE ADMINISTRATOR THAT HE WILL MAKE THE PROVIDENCE HOSPITAL ISSUE ONE OF HIS FIRST PRIORITIES.

I LOOK FORWARD TO HEARING THE TESTIMONY. THANK YOU, MR. CHAIRMAN.

Statement by Senator John D. Rockefeller IV
Veterans Affairs' Committee: VA Medical Construction
April 10, 1986

Thank you, Mr. Chairman. I have a great deal of interest in the subject of this hearing. I appreciate the effort that all of the witnesses have made to provide useful, detailed information to assist this committee in understanding and addressing the issues associated with the VA's construction program.

As the representatives of the veterans service organizations emphasize in their testimony, the budget for construction is of major importance. The President's budget requests a reduction of $210 million for major construction from the $511 million that CBO calls "current services" for fiscal year 1987. I share the view of most or all of my colleagues on this committee, that this cut would be excessive and jeapordize the health care for veterans dependent on certain facilities in urgent need of major renovation and additional space.

I am heartened by the action taken by the Senate Budget Committee. In the bipartisan budget plan it recently approved, the committee included the funding recommendations for veterans programs which were submitted by several of my colleagues on the veterans committee and myself. An additional $35 million for major construction is included in this Budget Committee proposal, which would provide funds for a greater number of urgently needed projects than what is included in the Administration's budget request.

I am here to learn as much as possible about the evolving decision-making process conducted by the VA to determine, schedule, and fund construction projects. More specifically, as most of you know, I have taken a strong interest in the clinical improvement addition for the VA medical center in Huntington, West Virginia. The VA includes this project in its most recent "Five Year Medical Facility Construction Needs Assessment."

The Huntington clinical addition would correct and address numerous deficiencies in the existing facility. These problems stem from the age of the hospital -- built in 1932, it is one of the first constructed by the VA -- and from the significant increases in patient demand that began in 1976 when the hospital was affiliated with Marshall University's Medical School. Since 1976, the number of inpatient and outpatient incidents of care has nearly doubled on an annual basis.

I am gravely concerned about the quality and scope of health care provided to the veterans dependent on this hospital. My impression is the Huntington hospital director and his personnel are making a tremendous effort to perform the VA's medical mission within the constraints of space shortages, antiquated conditions, the lack of critical technologies, and safety and fire deficiencies. But with the combination of the increased demand for care that occurred in the last ten years and the additional influx of older patients expected in the near future by the hospital, I believe that Huntington must be be included in the VA's list of top and immediate priorities for construction funds.

I urge the VA to assist me in addressing Huntington's situation. I have pledged to the veterans of West Virginia and all those associated with the Huntington VA hospital that I will do everything necessary to obtain the resources needed to upgrade this facility and correct whatever problems exist. It is my hope that the VA will agree that the time has arrived to begin the proposed clinical addition project.

II

99TH CONGRESS
2D SESSION

S. 2141

To prohibit the Administrator of Veterans' Affairs from carrying out certain proposed real estate transactions.

IN THE SENATE OF THE UNITED STATES

MARCH 5 (legislative day, FEBRUARY 24), 1986

Mr. CRANSTON (for himself, Mr. MATSUNAGA, Mr. DECONCINI, Mr. MITCHELL, and Mr. ROCKEFELLER) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To prohibit the Administrator of Veterans' Affairs from carrying out certain proposed real estate transactions.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Administrator of Veterans' Affairs may not declare as excess to the needs of the Veterans' Administration, or otherwise take any action to dispose of, the land and improvements at the Veterans' Administration Medical Center, West Los Angeles, California (consisting of approximately 109 acres), and at the Veterans' Administration Medical Center, Sepulveda, California (consisting of approximately 46 acres), described in letters dated February 5, 1986 (and enclosed maps), from the Administrator to the Committees on Veterans' Affairs of the Senate and the House of Representative pursuant to section 5022(a)(2) of title 38, United States Code.

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INTRODUCTORY STATEMENT

[From the Congressional Record, Vol. 132, No. 24, pp. S2094-S2095--Senate, March 5, 1986]

S. 2141. A bill to prohibit the Administrator of Veterans' Affairs from carrying out certain proposed real estate transactions; to the Committee on Veterans' Affairs.

PROHIBITING PROPOSED EXCESSING OF VA PROPERTY IN SOUTHERN CALIFORNIA

Mr. CRANSTON. Mr. President, as the ranking minority member of the Committee on Veterans' Affairs, I am today introducing, for myself and the Senators from Hawaii (Mr. Matsunaga), Arizona (Mr. DeConcini), Maine (Mr. Mitchell), and West Virginia (Mr. Rockefeller), all of whom also serve on the Veterans' Affairs Committee, S. 2141, a measure to prohibit the Veterans' Administration from declaring as excess several parcels of land at VA medical centers in southern California and thereby permitting the property to be disposed of by the General Services Administration (GSA) under Government-wide disposal guidelines.

On February 5, the VA's acting Administrator, Everett Alvarez, Jr. in accordance with the provisions of section 5022(a)(2) of title 38, United States Code, advised the Committees on Veterans' Affairs of the Senate and of the House, of the VA's intention "to declare as excess to the needs of the Veterans' Administration certain land and improvements at the VA Medical Center, West Los Angeles, approximately 109 acres, and the VA Medical Center, Sepulveda, approximately 46 acres." The VA noted that GSA estimates that $360 million in revenues will be generated by the disposal of this acreage and this amount is reflected as savings in the President's fiscal year 1987 budget.

Under the provisions of section 5022(a)(2) of title 38, VA land cannot be transferred during the 180-day period following notice to the Veterans' Affairs Committees of the plan to dispose of it. Since notice was given regarding these properties on February 5, the land may be declared excess on August 4 unless Congress has by then enacted legislation prohibiting the excessing.

That is the purpose of the legislation I am introducing today.

Mr. President, the proposal for the excessing and disposal of this VA property is a bad idea for several reasons.

First, it is a phoney budget reduction as to fiscal year 1987. Even if the Government's title to the property were free and clear—which, as I will explain, it is not—and the GSA were free to bring disposal processes now, experience demonstrates that it would take at least 2 to 3 years for the Government to consumate a sale of the property.

Second, however, as I noted, the land cannot be declared excess to the VA's needs before August 4 and the Government's title to the portions of the land in question at the VAMC in West Los Angeles is not free and clear. According to the VA's General Counsel, the Government's title to the West Los Angeles land has a cloud on it that will depress the market price greatly unless and until it is removed. Litigation to clear up the Government's title could take years since the heirs—apparently more than 150 of them—of the donors of the land have publicly stated their opposition to a sale.

Much of the land at the West Los Angeles VAMC was deeded in 1888 to the National Home for Disabled Volunteer Soldiers—a predecessor of the VA—on the express written condition that it be used for a branch of the home. The VA General Counsel rendered an opinion on December 30, 1985, concluding that, despite the deed condition, the land may be legally disposed of. However, he noted that sufficient uncertainty exists regarding the effect of the deed condition as to make it extremely difficult to market the land, especially since the heirs of the grantors have made it known that they are prepared to sue to try to get the land back if the VA sells it. Thus, he recommended that the Attorney General be requested to file suit to obtain a judicial declaration removing any cloud from the VA's title to the land. In either case, the ensuing litigation could drag on in the courts for years.

Third, Mr. President, it is my understanding that the VA believes it needs the land and OMB is forcing the VA to give it up to be sold off. The GSA survey on which the proposed excessing is based was completed more than 3 years ago, yet was made available to the VA only in January of this year when the proposed excessing was forced on the VA by OMB in connection with negotiations surrounding the agency's fiscal year 1987 budget. Indeed, at the February 6 House Veterans' Affairs Committee's hearing on the VA's fiscal year 1987 budget, Acting VA Administrator Alvarez indicated that he agreed with that committee's chairman's statements in opposition to the excessing of these lands.

The land gives the VA latitude for possible expansion in the future. In the case of the West Los Angeles VAMC, the land could be used for the expansion of the adjacent national cemetery, which is closed to new burials, and the relocation onto VA land of the VA's regional office thereby avoiding the rent—about $4 million per year—the VA Los Angeles regional office, located in the nearby Federal Building pays to GSA. In the cases of both VAMC's, the land also provides a necessary buffer zone between the medical facilities and surrounding communities. In addition, it may be possible to devise a plan under which the land could be temporarily used for other purposes, with the VA developing leasing or sharing plans for such temporary use, retaining title, and collecting revenues.

Fourth, Mr. President, is the opposition in the community to the excessing and sale of the property. The neighbors, quite properly, strongly oppose the congestion and disruption from the resulting construction and development. All the major veterans organizations have expressed opposition to the proposal.

Fifth, there are a number of factors—in addition to the problems with the deed—that, at the present time, could prevent the property from being sold at a fair market price and thereby prevent the Government from realizing maximum proceeds from any disposition of the property. These include a current moratorium on new access cuts into Wilshire Boulevard in West Los Angeles which would necessarily restrict the use of the land by a developer. In addition, on one of the parcels of land in West Los Angeles, several structures—including one built in 1906—could conceivably be designated as historic buildings, thus impeding new development and effective use of the property. In the case of the land at Supulveda, there are existing leases with city and civic organizations that encumber the land.

Sixth, Mr. President, I believe strongly that not all land, especially not all land in already high density areas in and around residential neighborhoods, should be developed. The lands in question constitute important open spaces and buffer areas for the communities involved.

Finally, Mr. President, I note my very strong contention that, if any sales were to occur, the proceeds should be used for the benefit of veterans, not the U.S. Treasury, especially in the case of the West Los Angeles land which was deeded to the VA's predecessor agency expressly for the use of veterans.

Mr. President, I realize that this issue may appear to be solely a California issue and that some Senators may be tempted to dismiss it as a local matter. However, it is far from that. OMB is not following the law here. In 1983, Congress expressly changed the law as to VA land so that the Administrator, not GSA or OMB, would have the final word in determining whether land is no longer needed by the Veterans' Administration in carrying out its functions. In this case, OMB has substituted its judgment for the head of the VA's.

Major national veterans' organization—the American Legion, the Disabled American Veterans, and the Paralyzed Veterans of America—have spoken out in opposition to the Administration's proposal. On the House side, the chairman of the House Committee on Veterans' Affairs—Mr. Montgomery—together with the chairman of that Committee's Subcommittee on Health and Hospitals—Mr. Edgar—have introduced legislation, H.R. 4204, to accomplish the same objective as my bill. Neither of these gentleman represent California.

The OMB-forced proposal to excess this property—at the expense of our Nation's vetefans—solely to achieve an artificial budget reduction is shortsighted and ill-advised. For the VA or any Federal agency to be required—against its better judgment—to dispose of valuable resources is simply wrong.

[Excerpt from the Democratic members recommendations to the Senate Budget Committee]

The President's FY 1987 budget assumes $360 million in revenue from the sale of certain parcels of land at the West Los Angeles and Sepulveda VA Medical Centers in California. We urge that such revenues not be anticipated in the FY 1987 budget.

On February 5, 1986, based on a 3-year old General Services Administration survey that the VA did not receive until January 1986, the Acting Administrator of Veterans' Affairs provided the Committees on Veterans' Affairs with notice of the proposed disposal of the parcels. Even if that letter is determined to satisfy the 180-day advance-notice provision in section 5022(a)(2) of title 38, the VA may not report the property to the GSA as excess to the VA's needs until August 4, 1986. At that point the GSA would undertake to dispose of the property, a process that takes two to three years on the average.

The 5 parcels in question at the West Los Angeles VAMC -- along with much other land there -- were deeded in 1888 to the National Home for Disabled Volunteer Soldiers -- a predecessor of the VA -- on the express written condition that it be used for a branch of the Home. The VA General Counsel rendered an opinion on December 30, 1985, concluding that, despite the deed condition, the land may be legally disposed of. However, he noted that sufficient uncertainty exists regarding the effect of the deed condition as to make it extremely difficult to market the land, especially since the heirs of the grantors have made it known that they are prepared to sue to try to get the land back if the VA sells it. Thus, he recommended that the Attorney General be requested to file suit to obtain a judicial declaration removing any cloud from the VA's title to the land. In either case, the ensuing litigation could drag on in the Federal courts for years.

We also note the opposition in the community to the excessing and sale of the property. The neighbors, quite properly, strongly oppose the congestion and disruption from the resulting construction and development. All the major State veterans organizations have expressed opposition to the proposal.

Moreover, there are a number of factors -- in addition to the problems with the West Los Angeles deed -- that, at the present time, could prevent the property from being sold at a fair market price and thereby prevent the government from realizing maximum proceeds from any disposition of the property. These include a current moratorium on new "access cuts" into Wilshire Boulevard in West Los Angeles which would restrict the use of the land by a developer. In addition, on one of the parcels of land in West Los Angeles, several structures -- including one built in 1906 -- could conceivably be designated as historic buildings, thus impeding new development and effective use of the property. In the case of the land at Sepulveda, there are existing leases with city and civic organizations that encumber the land.

Thus, based on the cloud on the Government's title at West Los Angeles and strong opposition in both local communities and from the state veterans organizations to the sales, as well as the length of time it takes GSA to complete the excessing process, we consider the claim of producing FY 1987 revenues totally unrealistic. Moreover, we believe that no deficit reduction should be claimed for the sales in any event because any proceeds should be turned over to the VA to be used for the benefit of veterans (especially in the case of the West Los Angeles land, where the deed to a Government agency was expressly conditioned on the land being used for veterans' benefits). Finally, in view of the VA's General Counsel opinion regarding the effect of the cloud on the Government's title to the West Los Angeles land on its market value, no plan for excessing should go forward as to the West Los Angeles land until legal action definitively determines the VA's right, contested by the donors' heirs, to sell the land.

We note that the Chairman's proposal also includes the recommendation that no deficit reduction should be assumed to result from any disposal of these properties.

STATEMENT
BY
THOMAS K. TURNAGE
ADMINISTRATOR
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON
APRIL 10, 1986

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, I AM PLEASED TO APPEAR BEFORE YOU THIS MORNING TO PRESENT TESTIMONY CONCERNING THE VA'S CONSTRUCTION PROGRAM. IN ADDITION TO THE VA'S FY 1987 CONSTRUCTION AUTHORIZATION REQUEST, MY TESTIMONY ADDRESSES THE ISSUES REQUESTED IN YOUR LETTER TO THE VA ANNOUNCING THE HEARING EXCEPT FOR THE PROPOSAL TO REORGANIZE THE VA CONSTRUCTION OFFICE. I APPRECIATE YOUR COMMITTEE ALLOWING ME SOME TIME TO REVIEW THE PROPOSED REORGANIZATION BEFORE HEARINGS ARE HELD. OUR STATEMENT ALSO ADDRESSES SENATOR CRANSTON'S PROPOSAL (S. 2141) TO PROHIBIT EXCESSING VA LAND AT THE WEST LOS ANGELES AND SEPULVEDA VA MEDICAL CENTERS.

AS YOU KNOW, WE HAVE A TREMENDOUS CAPITAL INVESTMENT REPRESENTED BY OVER 5,000 SEPARATE BUILDINGS. OVER 53 PERCENT OF OUR HOSPITAL BEDS ARE IN BUILDINGS WHICH ARE OVER 30 YEARS OLD. THE VA MUST MAINTAIN A PHYSICAL PLANT CAPABLE OF DELIVERING STATE OF THE ART MEDICAL CARE; ONE WHICH CAN KEEP PACE WITH MODERN MEDICAL ADVANCES; AND RESPOND TO THE CHANGING NEEDS OF THE AGING VETERAN POPULATION. OUR CONSTRUCTION PROGRAM REPRESENTS A COMMITMENT TO A CAPITAL INVESTMENT PROGRAM WHICH IS DEDICATED TO MEETING THE FACILITY NEEDS OF A

MODERN, COMPREHENSIVE HEALTH CARE DELIVERY SYSTEM TO PROVIDE FOR OUR NATION'S VETERANS.

CONSTRUCTION AUTHORIZATION REQUEST

THE FY 1987 BUDGET REQUESTS A PROGRAM LEVEL OF $465,170,000. THIS AMOUNT INCLUDES AN APPROPRIATION REQUEST FOR A MAJOR PROGRAM OF $358,208,000 WHICH INCLUDES $57 MILLION THAT IS AVAILABLE FROM PREVIOUS APPROPRIATIONS. WE ARE REQUESTING APPROVAL FOR FUNDING TEN MAJOR MEDICAL PROJECTS, $5 MILLION FOR THE ADVANCE PLANNING FUND TO DEVELOP FUTURE YEAR PROJECTS, $9.9 MILLION FOR ASBESTOS ABATEMENT, AND $19 MILLION FOR THE DESIGN FUND. WE ARE REQUESTING FUNDING FOR CONSTRUCTION OF MAJOR REPLACEMENT FACILITIES AT BOTH AUGUSTA (UPTOWN DIVISION), GEORGIA, AND BALTIMORE, MARYLAND. THE PROJECT AT AUGUSTA WILL PROVIDE FOR 590 HOSPITAL AND 60 NURSING HOME CARE BEDS, WHILE THE BALTIMORE PROJECT WILL PROVIDE 324 HOSPITAL BEDS. WE ARE REQUESTING FUNDING FOR THE DESIGN OF A BED REPLACEMENT AND MODERNIZATION PROJECT AT DAYTON, OHIO, AND FOR AN ENVIRONMENTAL IMPROVEMENTS, PATIENT AND NURSING HOME CARE BUILDINGS PROJECT AT NORTH CHICAGO, ILLINOIS. IN ADDITION, THIS BUDGET REQUEST INCLUDES TWO CLINICAL IMPROVEMENT PROJECTS, ONE FIRE AND SAFETY IMPROVEMENTS PROJECT, ONE ELECTRICAL IMPROVEMENTS PROJECT, ONE GENERAL PROJECT AND ONE RESEARCH AND EDUCATION PROJECT. OUR MINOR CONSTRUCTION PROGRAM REQUEST OF $106,967,000 INCLUDES $57,877,000 FOR THE CONSTRUCTION OF MEDICAL RELATED PROGRAMS. INCLUDED IN THIS REQUEST IS $4 MILLION FOR THE CONVERSION OF EXISTING BUT VACANT HOSPITAL BEDS TO NURSING HOME BEDS.

THE FY 1987 CONSTRUCTION BUDGET REQUEST IS BASED ON THE RESULTS OF THE DM&S MEDICAL DISTRICT INITIATED PROGRAM PLANNING (MEDIPP) PROCESS. THROUGH THIS PROCESS, THE VA'S 27 MEDICAL DISTRICTS DEVELOP PLANS TO PROVIDE NEEDED SERVICES

TO THOSE VETERANS WHO USE THE VA HEALTH CARE SYSTEM IN THEIR DISTRICT. THESE PLANS, WHICH IDENTIFY AND JUSTIFY MEDICAL PROGRAMS AND LEVELS OF SERVICE ARE REVIEWED, MODIFIED (IF NECESSARY) AND APPROVED IN VA CENTRAL OFFICE. THE LINKAGE BETWEEN THIS MEDIPP PROCESS AND THE CONSTRUCTION PLANNING PROCESS CAN BE OBSERVED IN LIGHT OF THE THREE DISTINCT LEVELS OF APPROVAL THAT EXIST IN THE MEDIPP PROCESS: NAMELY, (1) CONCURRENCE WITH A MEDIPP NEEDS ASSESSMENT; (2) APPROVAL FOR ADVANCED MEDIPP IMPLEMENTATION PLANNING; AND (3) APPROVAL FOR INCLUSION IN THE ADMINISTRATOR'S BUDGET PROPOSAL. ANY ITEM WHICH DOES NOT HAVE MEDIPP APPROVAL CANNOT BE CONSIDERED IN THE CONSTRUCTION PLANNING PROCESS. THE DEVELOPMENT OF THE FACILITY FIVE-YEAR CONSTRUCTION PLAN IS GOVERNED BY THE MEDIPP APPROVAL LEVEL. SINCE APPROVAL AT LEVEL 1 MEANS ONLY THAT THE ASSESSMENT OF NEED IS CERTIFIED, THE ITEMS MAY OR MAY NOT PROCEED TO LEVELS 2 AND 3. PROJECTS MAY ADVANCE BASED ON FURTHER DEVELOPMENT OF THE PROPOSAL AND CONSIDERATION OF THE PROJECT IN THE BUDGET PROCESS. ITEMS APPROVED AT LEVELS 2 AND 3 ARE INCLUDED IN THE ANNUAL DM&S IMPLEMENTATION PLAN AND, WHERE CONSTRUCTION IS NECESSARY TO MEET THE CLINICAL NEEDS, IN THE FIVE-YEAR FACILITY PLAN. THE APPROVED MEDIPP PLAN THEN SERVES AS THE BASIS FOR THE DEVELOPMENT BY EACH MEDICAL CENTER OF A FIVE YEAR FACILITY PLAN WHICH IDENTIFIES FACILITY DEFICIENCIES AND REQUIREMENTS AND THE PHYSICAL PLANT IMPROVEMENTS NECESSARY TO MEET PROGRAMMATIC OBJECTIVES. FROM THESE PLANS WE DEVELOP OUR FIVE YEAR MEDICAL FACILITY CONSTRUCTION NEEDS ASSESSMENT WHICH IS SUBMITTED ANNUALLY TO CONGRESS.

THE AGENCY CONSTRUCTION BUDGET DEVELOPMENT PROCESS HAS BEEN SIGNIFICANTLY IMPROVED THIS YEAR BY THE DEVELOPMENT OF A NEW METHODOLOGY TO ASSIST IN PRIORITIZING MAJOR CONSTRUCTION PROJECTS. THIS METHODOLOGY WHICH HAS BEEN DISCUSSED WITH THE COMMITTEE STAFF, FOCUSES ON THE PHYSICAL AND PROGRAMMATIC CHARACTERISTICS OF EACH PROJECT AND PROVIDES NUMERICAL SCORES WHICH CAN BE CONSIDERED IN ESTABLISHING PRIORITIES. THIS METHODOLOGY WAS USED TO RANK THE

PROJECTS IN THE FY 1987 BUDGET PROPOSAL CURRENTLY BEFORE YOU AND WILL BE USED IN FUTURE BUDGET SUBMISSIONS, AS WELL AS IN THE DEVELOPMENT OF THE FIVE YEAR MEDICAL FACILITY CONSTRUCTION NEEDS ASSESSMENT. I WOULD NOTE, HOWEVER, THAT THIS SYSTEM DOES NOT SUPPLANT THE NEED FOR EXECUTIVE REVIEW BY THE CHIEF MEDICAL DIRECTOR AND THE ADMINISTRATOR TO INSURE THAT CIRCUMSTANCES AND CONDITIONS WHICH MIGHT NOT BE ADDRESSED BY THE METHODOLOGY ARE CONSIDERED IN FORMULATING AGENCY PRIORITIES.

I WOULD LIKE TO SPEAK FOR A MOMENT ABOUT LONG TERM CARE. ALTHOUGH THERE ARE NO SEPARATE NEW NURSING HOME CARE PROJECTS IN OUR REQUEST, THE REPLACEMENT/MODERNIZATION PROJECTS FOR AUGUSTA, GEORGIA, AND NORTH CHICAGO, ILLINOIS, WILL PROVIDE 190 NEW NURSING HOME CARE BEDS. OUR BUDGET REQUEST REFLECTS A POLICY OF MEETING VETERANS NURSING HOME CARE NEEDS PRIMARILY THROUGH CONVERSION OF UNDER-UTILIZED HOSPITAL BEDS AND A GREATER USE OF COMMUNITY AND STATE FACILITIES. IF, HOWEVER, WE FEEL THAT IDENTIFIED LONG TERM CARE NEEDS CANNOT BE MET THROUGH CONVERSION, OR THROUGH COMMUNITY AND STATE HOME FACILITIES, NEW CONSTRUCTION WILL BE CONSIDERED. MAJOR CONSTRUCTION PROJECTS FUNDED IN FISCAL YEARS 1985 AND 1986 WILL ADD 1,090 NEW VA NURSING HOME CARE BEDS. IN OUR MINOR CONSTRUCTION REQUEST FOR FY 1987, WE HAVE INCLUDED $4.0 MILLION FOR CONVERSIONS OF HOSPITAL BEDS TO NURSING HOME CARE BEDS. AN ADDITIONAL 59 BEDS THAT DO NOT REQUIRE CONSTRUCTION FUNDING WILL BE CONVERTED TO NURSING HOME CARE USE IN FY 1987. IN ADDITION, OUR FY 1987 REQUEST FOR THE STATE HOME PROGRAM DOUBLES THAT PROGRAM FROM $21 MILLION TO $42 MILLION.

CONSIDERATION OF LEASE/PURCHASE OPTIONS

THE VA, CONSISTENT WITH THE INTENT OF P.L. 99-166, INTENDS TO GIVE CONSIDERATION TO THE LEASE OR PURCHASE OF EXISTING PRIVATE SECTOR FACILITIES AS AN ALTERNATIVE

TO CONSTRUCTING NEW OR REPLACEMENT FACILITIES. IN SUCH AN INSTANCE, THE VA WILL IDENTIFY AND EVALUATE EXISTING MEDICAL FACILITIES WHICH CAN POTENTIALLY SERVE AS AN ALTERNATIVE TO NEW VA CONSTRUCTION. THIS EVALUATION WILL INCLUDE AN ECONOMIC COST ANALYSIS (ECA) OF SUFFICIENT DETAIL TO ACCURATELY DETERMINE THE COST OF ACQUISITION AND ANY NECESSARY MODERNIZATION OF THE FACILITY TO ACCOMMODATE THE VA NEEDS. THE INFORMATION GAINED IN THE ECA WILL BE USED BY THE AGENCY TO COMPARE THE COST OF ACQUISITION TO NEW CONSTRUCTION AND MAKE DECISIONS REGARDING THE BEST APPROACH TO BE TAKEN.

DELEGATION OF MAJOR CONSTRUCTION

THE CONFERENCE COMMITTEE REPORT FOR THE FY 1985 MAJOR CONSTRUCTION APPROPRIATION ENCOURAGED THE VA TO DELEGATE AUTHORITY FOR CERTAIN CATEGORIES OF MAJOR CONSTRUCTION PROJECTS TO THE MEDICAL CENTER DIRECTORS. THE VA SELECTED 37 PROJECTS TO BE DELEGATED TO THE MEDICAL CENTER DIRECTORS FROM THE FY 1985 AND FY 1986 MAJOR CONSTRUCTION PROGRAM CONSISTENT WITH THAT REPORT. THIRTY-THREE OF THE 37 PROJECTS HAVE BEEN DELEGATED TO THE MEDICAL CENTER DIRECTORS. MORE RECENTLY P.L. 99-190 DIRECTED THE VA TO DELEGATE NO LESS THAN 15 OF THE FY 1985 MAJOR CONSTRUCTION PROJECTS AND NOT LESS THAN 10 OF THE FY 1986 MAJOR CONSTRUCTION PROJECTS IN THE MANNER AND UNDER THE CONDITIONS ESTABLISHED FOR THE EARLIER DELEGATION OF THE THREE NURSING HOME CARE UNIT CONSTRUCTION PROJECTS. TWENTY-FIVE OF THE THIRTY-THREE PROJECTS HAVE BEEN SELECTED AND THE TERMS AND CONDITIONS OF THEIR DELEGATION ARE BEING MODIFIED AS REQUIRED BY THE PUBLIC LAW.

THE MOST CRITICAL INPUT FROM MEDICAL CENTER PERSONNEL OCCURS DURING THE EARLY PLANNING PHASE, INCLUDING CONCEPTUAL DEVELOPMENT AND PRELIMINARY DESIGN. IN THE PAST YEAR, NEW INITIATIVES HAVE ENABLED MEDICAL CENTER MANAGEMENT AND STAFF TO HAVE A MAJOR ROLE IN PROJECT PLANNING. THESE INITIATIVES INCLUDE VA MEDICAL CENTER PARTICIPATION IN ARCHITECT/ENGINEER SELECTION, DIRECT INTERACTION BETWEEN THE ARCHITECT/ENGINEER AND THE MEDICAL CENTER DURING DESIGN, AND GREATER INVOLVEMENT IN PROJECT REVIEW. WE ANTICIPATE THAT IMPLEMENTATION OF THE BOOZ ALLEN CORE PROCESS RECOMMENDATIONS WILL FURTHER STRENGTHEN THE ENTIRE PLANNING PROCESS AND THE MEDICAL CENTER'S INVOLVEMENT IN THAT PROCESS THEREBY ACHIEVING THE NEEDED PARTICIPATION THAT DELEGATION WAS INTENDED TO ACHIEVE.

OPTIONS FOR PROVIDING PARKING

IN REPORT LANGUAGE ACCOMPANYING THE VA FY 1986 APPROPRIATION ACT, THE SENATE APPROPRIATIONS COMMITTEE DIRECTED THE VETERANS ADMINISTRATION TO DEVELOP "A PROGRAM BY WHICH PARKING FACILITIES CAN BE PROVIDED AT VA MEDICAL CENTER SITES AND THE COSTS PAID FOR OR AMORTIZED BY THE CHARGING OF USER FEES." WE HAVE FORMED A TASK FORCE TO STUDY OPTIONS TO ACCOMPLISH THIS PURPOSE AND ANTICIPATE RECEIVING RECOMMENDATIONS IN THE NEXT FEW WEEKS.

MR. CHAIRMAN, YOU ALSO REQUESTED THAT WE COMMENT ON THE PARKING SITUATION AT THE VA MEDICAL CENTER IN SAN FRANCISCO. WE HAVE BEEN SEEKING A SOLUTION TO A SERIOUS PARKING SITUATION AT THIS VA MEDICAL CENTER FOR A NUMBER OF YEARS. EFFORTS TO NEGOTIATE A LONG TERM AGREEMENT WITH THE NATIONAL PARK SERVICE TO PARK ON EXISTING PARK LAND HAVE FAILED, AND CONGRESSIONAL CONSIDERATION OF THIS ISSUE HAS NOT PRODUCED A SOLUTION. THE UNCERTAINTY OVER MEETING OUR FUTURE REQUIREMENTS RAISES QUESTIONS ABOUT CONTINUING TO PROCEED WITH THE FY 1984 FUNDED PROJECT TO CONSTRUCT A 120-BED NURSING HOME CARE UNIT. THE PRESENT SPECIAL USE PERMIT FOR SURFACE PARKING WILL EXPIRE IN APRIL AND THE NATIONAL

PARK SERVICE HAS AGREED TO EXTEND THIS PERMIT FOR AN ADDITIONAL 5 YEARS ON THE CONDITION THAT THE VA MAKE CERTAIN IMPROVEMENTS TO THE PARKING LOT AND THAT VA PROCEED WITHIN THIS TIME FRAME WITH THE CONSTRUCTION OF THE FOUR-LEVEL PARKING STRUCTURE ON VA LAND AT THE SAN FRANCISCO VA MEDICAL CENTER. THE SITUATION IS CURRENTLY UNDER REVIEW.

GRAMM-RUDMAN IMPACT FOR FY 1986 AND FY 1987

WE HAVE ATTACHED TO OUR STATEMENT COMPLETE LISTINGS OF FY 1986 MAJOR PROJECTS AND LINE ITEMS, AND MINOR LINE ITEM CATEGORIES AS INCLUDED IN THE FY 1987 CONGRESSIONAL BUDGET SUBMISSION. THESE SHOW THAT REDUCTIONS OF 3.1% WERE MADE TO ALL AMOUNTS DERIVED FROM THE FY 1986 APPROPRIATION FOR EACH PROJECT AND LINE ITEM IN THE MAJOR PROGRAM, AND 4.3% IN ALL LINE ITEM CATEGORIES IN THE MINOR PROGRAM. BECAUSE PART OF THE FUNDING FOR MAJOR PROJECTS IS PROVIDED FROM PRIOR APPROPRIATIONS, THE PRO-RATA REDUCTION IS CALCULATED AT 3.1%.

TO MEET THESE REDUCTIONS, DESIGNS WILL BE RESTUDIED AND REVISED IF NECESSARY TO ACHIEVE THE DOLLAR REDUCTIONS, AND IT IS PLANNED TO MAKE THE NECESSARY CHANGES WITHIN CURRENT SCHEDULES. IN MOST CASES, IT APPEARS THAT THE LOWER COSTS CAN BE ACHIEVED WITH LITTLE, IF ANY, IMPACT ON PATIENT CARE, FTEE, AND ACTIVATIONS. IF IT IS FOUND THAT THERE ARE UNDESIRABLE IMPACTS, SCOPE REDUCTIONS FOR REPROGRAMMINGS OF SELECTED PROJECTS MAY BE PROPOSED.

IN THE MINOR PROGRAM, SIMILAR STEPS WILL BE TAKEN TO RESTUDY THE PROJECTS. WHERE PROJECTS ARE NOT UNDER CONSTRUCTION, DESIGNS WILL BE RESTUDIED AND REVISED, IF NECESSARY, TO ACHIEVE THE DOLLAR REDUCTIONS. SOME PROJECTS MAY HAVE TO BE DEFERRED UNTIL FY 1987 IN SOME CATEGORIES.

FURTHER GRAMM-RUDMAN IMPACTS FOR FY 1987 WILL NOT BE KNOWN UNTIL OR IF AN FY 1987 SEQUESTRATION IS MADE.

VA/DOD SHARING

THE VA/DOD SHARING LAW WAS PASSED BY THE CONGRESS IN 1982. DURING THE LAST TWO AND A HALF YEARS OF THE PROGRAM'S IMPLEMENTATION, 89 VA MEDICAL CENTERS AND 119 OF THEIR MILITARY COUNTERPARTS HAVE NEGOTIATED 260 AGREEMENTS.

IN THE LAST QUARTER ALONE (JANUARY-MARCH 1986) 38 AGREEMENTS WERE NEGOTIATED. THIS IS THE HIGHEST NUMBER OF AGREEMENTS NEGOTIATED IN ANY QUARTER TO-DATE.

RECENTLY, THERE HAS BEEN MUCH ACTIVITY IN JOINT PLANNING FOR HOSPITAL FACILITIES. WHEREVER THERE IS EXCESS CAPACITY, THE BENEFITS FOR THE VA AND DOD ARE CLEAR WHETHER THE VA BUYS INPATIENT CARE FROM THE MILITARY OR THE MILITARY PURCHASES FROM THE VA. EXAMPLES OF EACH TYPE OF SHARING THAT ARE BEING CONSIDERED IN HOSPITAL CONSTRUCTION ARE:

VA PURCHASE HOSPITAL CARE - LAS VEGAS, NV, DOES NOT HAVE A VA HOSPITAL. THE AIR FORCE WANTS TO BUILD A NEW HOSPITAL. BY COMBINING WORKLOADS, ECONOMIES OF SCALE CAN BE REALIZED. THE AIR FORCE PLANS TO DEDICATE 54 OF THE 135 BEDS FOR VETERANS. VETERANS IN THE LAS VEGAS AREA GAIN GREATER ACCESS TO HEALTH CARE WITHOUT HAVING TO TRAVEL LONG DISTANCES.

VA PROVIDES HOSPITAL CARE - THE ALBUQUERQUE, NM, VA MEDICAL CENTER, WHICH HAS JUST COMPLETED CONSTRUCTION, HAS BEDS THAT COULD BE USED BY THE AIR FORCE FOR THEIR PATIENT LOADS. RATHER THAN BUILD A NEW SMALL HOSPITAL AND OUTPATIENT CLINIC AT ADJOINING KIRTLAND AIR FORCE BASE, THE AIR FORCE WOULD OCCUPY THE SIXTH FLOOR OF THE VA'S NEW CLINICAL SERVICES ADDITION. THE VAMC WOULD GAIN EXTRA EARNINGS AND A MORE FULLY UTILIZED HOSPITAL.

OTHER POTENTIAL SITES ARE BEING EXPLORED. RECENTLY AN ECONOMIC ANALYSIS OF THE FEASIBILITY OF INCLUDING VA BEDS AT A RENOVATED USAF HOSPITAL, ELMENDORF AIR FORCE BASE, AK, WAS COMPLETED. THE MAJORITY OF HEALTH CARE IN ALASKA IS PROVIDED ON A FEE BASIS ARRANGEMENT AND ALTERNATIVES FOR PROVIDING A PORTION OF THIS CARE, ESPECIALLY IN THE ANCHORAGE AREA, THROUGH OTHER SOURCES NEEDS TO BE EXPLORED.

ALTHOUGH FURTHER ANALYSIS IS NEEDED, IT IS CLEAR THAT VA/AIR FORCE COLLABORATIVE EFFORTS IN ALASKA HAVE THE POTENTIAL FOR BOTH SAVINGS AND IMPROVED QUALITY OF SERVICES.

AT HONOLULU, HI, THE VA IS STUDYING THE POTENTIAL FOR RENOVATION OF TRIPLER ARMY HOSPITAL'S "E-WING" TO MEET THE HEALTH CARE NEEDS OF VETERANS IN HAWAII. DURING 1986 THE REGION WILL COMPLETE ITS ANALYSIS AND MAKE RECOMMENDATIONS ON THE POSSIBILITY FOR A SHARING ARRANGEMENT BETWEEN THE VA AND TRIPLER.

MANY OTHER PROPOSALS ARE IN DISCUSSION AND FORMATIVE STAGES AT THE LOCAL VAMC/DOD FACILITY LEVEL. WE ARE STRONGLY ENCOURAGING THESE INITIATIVES WHENEVER THEY ARE CLEARLY ADVANTAGEOUS TO BOTH AGENCIES AND ULTIMATELY THE TAXPAYER.

S. 2141 (WEST LOS ANGELES/SEPULVEDA LAND)

MR. CHAIRMAN, THE COMMITTEE ALSO ASKED FOR MY COMMENTS ON THE PROPOSED LEGISLATION WHICH WOULD PROHIBIT THE VETERANS ADMINISTRATION FROM DISPOSING OF PROPERTY AT THE VA MEDICAL CENTERS AT WEST LOS ANGELES AND SEPULVEDA. AS I INDICATED AT MY CONFIRMATION HEARING, I SUPPORT RETENTION OF PROPERTY AT THESE MEDICAL CENTERS IF IT IS REQUIRED TO MEET VA NEEDS IN THE FUTURE. IN THIS REGARD, A STUDY IS UNDERWAY TO EXAMINE ALL RELEVANT INFORMATION AND INSURE THAT

THE DISPOSAL CURRENTLY PROPOSED WILL NOT COMPROMISE THE AGENCY'S ABILITY TO MEET FUTURE PROGRAM REQUIREMENTS. I DO NOT SUPPORT THE PENDING LEGISLATION BECAUSE IT WOULD PROVIDE A BLANKET PROHIBITION OF DISPOSAL AT THESE LOCATIONS EVEN IF IT IS ULTIMATELY DETERMINED THAT THE LAND IS NOT NECESSARY FOR VETERANS PROGRAMS.

THAT CONCLUDES MY FORMAL STATEMENT. I AND MEMBERS OF MY STAFF WILL BE PLEASED TO RESPOND TO ANY QUESTIONS THAT YOU OR MEMBERS OF THE COMMITTEE MAY HAVE.

CHANGES FROM ORIGINAL 1986 APPROPRIATION
(dollars in thousands)

The chart below reflects the major FY 1986 breakdown by project within category based on P.L. 99-160 versus the breakdown based on P.L. 99-177.

Location	Description	Original Estimated Cost	1986 Approp.	Current Estimated Cost	Adj. for P.L. 99-177
A. Medical Program:					
Replacement and Modernization:					
Allen Park, MI	Replacement and Modernization	$195,600	$ 26,760	$194,763	$- 837
Houston, TX	Replacement and Modernization	252,000	226,800	244,905	-7,095
Mountain Home, TN	Bed Towers and Renovation	70,300	59,000	68,454	-1,846
Philadelphia, PA	Clinical Addition, Renovation, Parking and 240-bed Nursing Home Care Unit	119,300	101,600	116,122	-3,178
Nursing Home Care:					
Amarillo, TX	120-bed Nursing Home Care Unit	6,500	6,500	6,296	- 204
Tucson, AZ	120-bed Nursing Home Care Unit	6,800	6,800	6,588	- 212
Domiciliaries:					
Temple, TX	408-bed Replacement Domiciliary	17,300	17,300	16,759	- 541
Wood, WI	Renovate Building 43 for Domiciliary	6,400	6,400	6,200	- 200
Other Improvements:					
Advance Planning Fund:					
Various Stations		4,000	4,000	3,875	- 125
Asbestos Abatement:					
Various Stations		35,000	35,000	33,905	-1,095
Clinical Improvements:					
Big Spring, TX	Renovate Surgery	3,700	3,700	3,584	- 116
Togus, ME	Clinical Improvements Building 200	30,700	30,700	29,740	- 960
Design Fund:					
Various Stations		15,000	15,000	14,531	- 469
Electrical Improvements:					
Hampton, VA	Electrical Systems Modernization	2,100	2,100	2,034	- 66
Long Beach, CA	Upgrade Secondary Electrical Distribution	5,300	5,300	5,134	- 166
Poplar Bluff, MO	Electrical Distribution System Improvements	2,000	2,000	1,937	- 63
Fire and Safety Improvements:					
Chicago(West Side), IL	Fire and Safety and Patient Privacy Improvements	6,600	6,600	6,393	- 207
Cleveland(Brecksville), OH	Fire and Safety Improvements	2,700	2,700	2,616	- 84
Cleveland(Wade Park), OH	Fire and Safety Improvements	5,200	5,200	5,037	- 163
Indianapolis, IN	Fire and Safety Improvements	5,000	5,000	4,844	- 156
Jackson, MS	Install Sprinkler System	3,000	3,000	2,906	- 94
Knoxville, IA	Fire and Safety Improvements	3,700	3,700	3,584	- 116
Topeka, KS	Fire and Safety, Patient Privacy and Electrical Improvements	18,150	10,000	17,837	- 313

CHANGES FROM ORIGINAL 1986 APPROPRIATION (Continued)
(dollars in thousands)

Location	Description	Original Estimated Cost	1986 Approp.	Current Estimated Cost	Adj. for P.L. 99-177
General Projects:					
Brooklyn(St. Albans Division), NY	Modernize Kitchen and Satellite Dining Areas	$ 4,800	$ 4,800	$ 4,650	$- 150
Chicago(West Side), IL	Renovation of Buildings 11A and 11B, Phase II	18,000	18,000	17,437	- 563
Coatesville, PA	New Kitchen and Dining Hall	6,300	6,300	6,103	- 197
Durham, NC	Boiler Plant	2,200	2,200	2,131	- 69
Hines, IL	180-bed Psychiatric Replacement Facility	23,000	23,000	22,281	- 719
Lyons, NJ	Renovate Buildings 7 and 57	13,600	13,600	13,174	- 426
St. Louis(Jefferson Barracks Division), MO	Remodel Building 53	9,900	9,900	9,590	- 310
Tomah, WI	Modernize Buildings 403 and 404	6,100	6,100	5,910	- 190
Seismic:					
St. Louis(Jefferson Barracks Division), MO	Seismic Corrections	15,500	15,500	15,015	- 485
San Diego, CA	Non-structural Seismic Corrections	6,300	6,300	6,103	- 197
B. National Cemetery Program:					
Florida	Develop 13,000 Gravesites and Construct Administration Building	6,500	6,500	6,296	- 204
	Subtotal	$928,550	$697,360	$906,734	$-21,816
	Less: Design Fund		- 10,000		
	Reprogramming	...	-180,000	...	...
	TOTAL	$928,550	$507,360	$906,734	$-21,816

CHANGES FROM ORIGINAL 1986 APPROPRIATION
(dollars in thousands)

The chart below reflects the minor FY 1986 category breakdown based on P.L. 99-160 versus the new breakdown based on P.L. 99-177.

	1986 APPROPRIATION	WITH 4.3% REDUCTION 1/
A. Medical Program	$ 92,136	$ 88,174
Nursing home care	10,000	9,570
Research and education	4,000	3,828
Outpatient improvements	1,000	957
Other improvements	77,136	73,819
Clinical improvements	(12,700)	(12,154)
Electrical improvements	(2,000)	(1,914)
Fire and safety improvements	(6,000)	(5,742)
General projects	(17,436)	(16,686)
Heating, ventilating, and air conditioning	(3,000)	(2,871)
Seismic improvements	(2,000)	(1,914)
Miscellaneous projects	(34,000)	(32,538)
B. Regional Office Program	2,000	1,914
C. National Cemetery Program	4,400	4,211
D. Computer Centers	2,000	1,914
E. Emergency Fund	500	478
F. General Administration	35,914	34,370
Total, budget authority	$136,950	$131,061

1/ This column reflects the effects of P.L. 99-177, the Balanced Budget and Emergency Deficit and Control Act of 1985.

[illegible]
[illegible]
[illegible]
ARLEN SPECTER, PENNSYLVANIA
JEREMIAH DENTON, ALABAMA
RUDY BOSCHWITZ, MINNESOTA

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STAFF DIRECTOR

United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

April 28, 1986

Dr. John Ditzler
Chief Medical Director
Veterans' Administration
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear John:

I am writing to confirm a commitment which was made by the Veterans' Administration (VA) during the April 10, 1986, Senate Committee on Veterans' Affairs hearing on matters relating to VA medical facility construction.

During the hearing, I requested that an evaluation of the availability of private sector beds as well as alternatives to the construction of acute care hospitals be examined in certain areas where the VA plans to construct new or replacement hospitals. It is my understanding that the VA agreed to conduct such an examination in the following areas: Baltimore, Maryland; Augusta, Georgia; Pittsburgh, Pennsylvania; and Palm Beach, Florida.

Thank you for your cooperation and I look forward to receiving this information in a timely manner.

Sincerely,

Frank

Frank H. Murkowski
Chairman

Veterans
Administration

MAY 12 1986

In Reply Refer To: 10A431

Honorable Frank H. Murkowski
Chairman, Committee on Veterans Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

This is in response to your letter of April 28, 1986, concerning the evaluation of the availability of private sector beds as an alternative to new Veterans Administration hospital construction in Baltimore, Maryland; Augusta, Georgia; Pittsburgh, Pennsylvania; and Palm Beach, Florida.

For the four areas involved, on April 24-25, 1986, we called community, state and county hospitals that fell within the range of 25 percent above or below the number of beds we were planning to construct in those areas. In addition, on April 30, 1986, letters were mailed to every hospital located within the county where we plan to construct a new medical center. In both the telephone call and the letter, we provided background information on our proposed facility as well as the reason for the request. In each instance, we requested if any facility was available for purchase or lease to respond by May 8, 1986. Also, on April 29, 1986, calls were made to the four State Hospital Associations advising them of our interests. These calls were also followed with a letter, dated April 30, 1986.

We will advise you of our findings and recommendations concerning any favorable responses that we receive.

Sincerely,

John W. Ditzler

JOHN W. DITZLER, M.D.
Chief Medical Director

[illegible]
of Veterans Affairs

Veterans
Administration

June 16, 1986

Honorable Frank H. Murkowski
Chairman, Committee on Veterans Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

On April 10, 1986, you requested that the Veterans Administration investigate the potential acquisition through lease or purchase of an existing hospital as an alternative to new construction in Augusta, Georgia; Baltimore, Maryland; Palm Beach County, Florida; and Pittsburgh, Pennsylvania.

In response to your request the Department of Medicine and Surgery contacted each hospital in the county where VA construction is planned. Enclosed is a report describing the efforts undertaken to identify potential opportunities. It is our conclusion that there are only two existing facilities available which may serve as alternatives to new construction. There is some indication that the offer from one of these facilities in Augusta is tentative and may be withdrawn, however, the other in Pittsburgh requires further assessment by an on-site evaluation team and a report incorporating their findings will be forwarded to your Committee within 30 days.

In the case of Baltimore and Palm Beach County, no existing facilities have indicated an interest in lease or sale. The VA continues to believe that the funding for a new Baltimore facility in FY 1987 is appropriate. The planning for Palm Beach County will continue with budget consideration in the future.

The Veterans Administration is committed to giving consideration to lease/purchase alternatives when the need for a new or replacement hospital has been identified. Formalized procedures are now being developed which will be utilized in the future and will support VA compliance with the requirement of PL 99-166, Section 303, to include in the project prospectus, a description of the lease/purchase consideration.

Your interest in this matter is appreciated.

Tom Turnage
THOMAS K. TURNAGE
Administrator

Enclosures

VETERANS ADMINISTRATION
DEPARMENT OF MEDICINE AND SURGERY

Report of Efforts to Pursue Lease/Purchase Alternatives to New Construction

1. PURPOSE: The purpose of this report is to describe efforts undertaken by the Veterans Administration, Department of Medicine and Surgery to investigate potential opportunities to acquire by lease or purchase existing hospitals as an alternative to VA construction of new or replacement VA medical centers.

2. BACKGROUND: On April 10, 1986, the Chairman, Senate Committee on Veterans Affairs requested the VA to investigate the potential to acquire existing hospitals as economical alternatives to planned new construction at Augusta, Georgia; Baltimore, Maryland; Palm Beach County, Florida; and Pittsburgh (Aspinwall), Pennsylvania. The Augusta and Baltimore projects are proposed in the FY 1987 budget. The projects at Palm Beach and Pittsburgh are planned for future budget consideration.

3. SURVEY PROCESS: The Department of Medicine and Surgery identified all hospitals located in the counties where construction of the four projects is planned. Each of these hospitals received a letter from the VA central office dated April 30, 1986, advising of VA interest and requesting a response indicating interest by May 8, 1986. In addition, those hospitals whose bed capacity was within (±) 25 percent of the planned VA bed capacity received a telephone call on April 24-25, 1986. The purpose of this call was to advise of VA's interest and of the coming letter and to answer any questions. The listing of all hospitals contacted is appended to this report as attachment no. 1. Those who received telephone calls are indicated on the list. A copy of the letter sent to each hospital is appended as attachment no. 2.

Also, on April 29, 1986, telephone calls were placed to the State Hospital Associations in the four states advising them of the VA's interest. We asked if they could provide any information on medical facilities that were potentially available for purchase or lease. These calls were confirmed by a letter, dated April 30, 1986.

4. RESPONSE: The following information was received in response to the inquiries:

Augusta, Georgia ---- One offer to sell was received and is currently being evaluated. An on-site evaluation will be conducted if the offer remains valid.

Baltimore, Maryland - No offers to lease or sell to the VA were received. Offers were received to provide a limited number of beds for VA patients in community facilities on a contract basis.

Palm Beach County, Florida -	No offers to lease or sell to VA were received. Offers were received to provide a limited number of beds for VA patients in community facilities on a contract basis.
Pittsburgh, Pennsylvania ---	One hospital has indicated an interest in lease/purchase. An on-site evaluation will be conducted and a report will be prepared within the next 30 days. This report will assess the viability of the offer and it will be made available to the Committee. There were no other offers received.

5. CONCLUSION: There are two existing facilities potentially available in the four areas in question which the VA might lease or purchase as an alternataive to construction.

Facility Planning Service (10A43)
Department of Medicine and Surgery
May 29, 1986

Attachment No. 2

10A431

Recently, the Senate Veterans Affairs Committee requested the Veterans Administration to contact hospitals in the Augusta area to determine if any local hospitals were available for sale or lease to the VA as an alternative to our planned construction of a replacement hospital. Congress has given us a very limited time to accomplish this task. We would like to know if your hospital is currently available for lease or purchase.

We plan to construct a 650 bed medical center with capacity to provide 51,900 annual outpatient visits in Fiscal Year 1995. Our medical center will consist of approximately 920,000 gross square feet of space. Enclosed is a copy of the general specifications of the facility we plan to construct. If you are interested in selling or leasing your facility, we would like you to provide us with the general specifications of your facility so we can make a preliminary decision of viability.

If your hospital does appear to be a viable alternative, we will make further arrangements to have an on-site evaluation done of your hospital.

We would appreciate a reply by May 8, 1986. Please call Mr. Charles F. Krewson or Mr. Robert O'Hara in Washington, D.C. on (202) 389-2452 if you are interested in potential sale or lease or if you require additional information.

Sincerely,

By Direction of the Chief Medical Director

ALAN T. MAURER
Director, Facility Engineering,
Planning and Construction Office

Enclosure

cc: Director (00)
VA Medical Center
Augusta, Georgia

Director (00)
VA Medical Center
Baltimore, Maryland

Director (00)
VA Medical Center
Pittsburgh, Pennsylvania

10BA2
10BA3

[SIMILIAR LETTERS WERE SENT TO THE FOLLOWING ADDRESSESS ON THE ATTACHED LISTING]

Attachment No. 1

Mr. John E. Strickland
Administrator
Aiken Community Hospital
P.O. Drawer 1117
Aiken, South Carolina 29801

Everette C. Kuglar, M.D.
Superintendent
Georgia Regional Hospital
P.O. Box 327
Gracewood, Georgia 30912

*Malcolm I. Page, M.D.
Administrator
Eugene Talmadge Memorial Hospital
Augusta, Georgia 30910

Mr. C. Wayne Peloquin
Executive Director
Humana Hospital - Augusta
Augusta, Georgia 30910

Mr. William S. Atkinson
Administrator
St. Joseph Hospital
2260 Wrightsboro Road
Augusta, Georgia 30910

*Mr. Edward Gillespie
Executive Director
University Hospital
1350 Walton Way
Augusta, Georgia 30910

Brig. Gen. Alcide Lanoue
Executive Officer
Dwight David Eisenhower Army Medical Center
Fort Gordon, Georgia 30905-5650

Mr. Lou Imbrogno
Administrator
Edgefield County Hospital
P.O. Box 590
Edgefield, South Carolina 29824

Bon Secours Hospital
Alvin M. Powers, Director
2000 W. Baltimore Street
Baltimore, Maryland

Children's Hospital
Stephen C. Loescher, CEO
3825 Greenspring Avenue
Baltimore, Maryland

*Church Hospital Corporation
Thomas Whedbee, President
100 N. Broadway
Baltimore, Maryland

Deaton Hospital and Medical Center
Wallace Dow, Administrator
611 S. Charles Street
Baltimore, Maryland

Francis Scott Key Medical Center
Ronald Peterson, President
4940 Eastern Avenue
Baltimore, Maryland

Franklin Square Hospital
Michael Merson, President and CEO
9000 Franklin Square Drive
Baltimore, Maryland

*Good Samaritan Hospital of Maryland
James Oakey, President
5601 Loch Raven Boulevard
Baltimore, Maryland

Greater Baltimore Medical Center
Robert Kowal, President
6701 N. Charles Street
Baltimore, Maryland

James Lawrence Kernan Hospital
William Currie, Executive Director
2200 North Forest Park Avenue
Baltimore, Maryland

Johns Hopkins Hospital
Dr. Robert Heyssel, President
600 N. Wolfe Street
Baltimore, Maryland

Luthern Hospital of Maryland
William Jews, President
730 Ashburton Street
Baltimore, Maryland

*Maryland General Hospital
J. R. Wood, President
826 Linden Avenue
Baltimore, Maryland

*Mercy Hospital
Sr. Mary Thomas, President
301 St. Paul Place
Baltimore, Maryland

*Hospitals that received telephone requests.

Montebello Hospital
Stephen Forstenzer, Director
2201 Argonne Drive
Baltimore, Maryland

Mount Washington Pediatric Hospital
Frank Pommett, President
1708 W. Rogers Avenue
Baltimore, Maryland

North Charles General Hospital
Irwin Bloom, Administrator
2724 N. Charles Street
Baltimore, Maryland

*Provident Hospital
George Russell, Trustee
2600 Liberty Heights Avenue
Baltimore, Maryland

Sinai Hospital of Baltimore
Dr. Spencer Foreman, President
Belvedere Avenue at Greenspring
Baltimore, Maryland

South Baltimore General Hospital
L. Barney Johnson, President and CEO
3001 S. Hanover Street
Baltimore, Maryland

St. Agnes Hospital
Sr. Mary Louise, Administrator
900 S. Canton Avenue
Baltimore, Maryland

St. Joseph Hospital
Sr. Marie Cecilia Irwin, President and CEO
7620 York Road
Baltimore, Maryland

Union Memorial Hospital
Charles Jenkins, President
201 E. University Parkway
Baltimore, Maryland

University of Maryland Medical Systems
Dr. Morton Rapoport, CEO
22 S. Greene Street
Baltimore, Maryland

Wyman Park Health System
Dr. Patrick Mattingly, President
3100 Wyman Park Drive
Baltimore, Maryland

John F. Kennedy Memorial Hospital
James K. Johnson, Administrator
P.O. Box 1489
Lake Worth, Florida 33460

Glades General Hospital
Patrick Lennon, Administrator
P.O. Box 9900
Belle Glade, Florida 33430

Boca Raton Community Hospital
Stephen J. Ladika, President
800 Meadows Road
Boca Raton, Florida 33432

Bethesda Memorial Hospital
Russell T. Clayton, President
2815 S. Seacrest Boulevard
Boynton Beach, Florida 33435

Delray Community Hospital
John D. Bartlett, Executive Director
5352 Linton Boulevard
Delray Beach, Florida 33445

Jupiter Hospital
Dino P. Cagni, Executive Director
1210 S. Dixie Highway
Jupiter, Florida 33458

Doctors Hospital of Lake Worth
Rodney F. Dorsette, Administrator
2829 Tenth Avenue, N.
P.O. Box 1649
Lake Worth, Florida 33460

A.G. Holley State Hospital
Dr. P. E. Lovic, M.D.
Lantana Road
P. O. Box 3084
Lantana, Florida 33465

Everglades Memorial Hospital
Donald A. Anderson, Administrator
P. O. Box 659
Pahokee, Florida 33476

Forty-Fifth Street Mental Health Center
Terry H. Allen, Executive Director
1041 45 Street,
West Palm Beach, Florida 33407

*Hospitals that received telephone requests.

Good Samaritan Hospital
Kenneth A. Weda, President
Flagler Dr. at Palm Beach Lake Boulevard
P. O. Box 3166
West Palm Beach, Florida 33402

Humana Hospital-Palm Beaches
Steve Sutherlin, Executive Director
2201 45th Street
West Palm Beach, Florida 33407

St. Mary's Hospital
John E. Fidler,
President and Chief Executive Officer
901 45th Street
West Palm Beach, Florida 33407

Allegheny General Hospital
David J. Campbell
320 East North Avenue
Pittsburgh, Pennsylvania 15212

Allegheny Valley Hospital
Mr. John England
1301 Carlisle Street
Natrona Heights, Pennsylvania 15065

Braddock General Hospital
Frederick Hough
400 Holland Avenue
Braddock, Pennsylvania 15104

Central Medical Center and Hospital
Thomas Gallagher
1200 Centre Avenue
Pittsburgh, Pennsylvania 15219

Children's Home of PGH
B. Marlene West
5618 Kentucky Avenue
Pittsburgh, Pennsylvania 15232

Divine Providence Hospital
Ronald Mangold
1004 Arch Street
Pittsburgh, Pennsylvania 15212

Forbes Metro Health Center
Richard T. Merk
225 Pennsylvania Avenue
Pittsburgh, Pennsylvania 15221

*Forbes Regional Health Center
Dana Ramish
2570 Haymarket Road
Monroeville, Pennsyvlania 15146

Harmarville Rehabilitation Center
Robert E. Henger
P. O. Box 11460, Guys Run Road
Pittsburgh, Pennsylvania 15238

*Allegheny County Commissioners
Thomas J. Foerster, Chairman
Room 119, Court House
Pittsburgh, Pennsylvania 15219

Mayview State Hospital
1601 Mayview Road
Birdgeville, Pennsylvania 15017

*McKeesport Hospital
1500 Fifth
McKeesport, Pennsylvania 15132

Mercy Hospital of PGH
Sister Joanne Marie Andiorio
1400 Locust Street
Pittsburgh, Pennsylvania 15219

North Hills Passavant Hospital
Alexander McAlliey
9100 Babcock Boulevard
Pittsburgh, Pennsyvlania 15237

Ohio Valley General Hospital
William Provenzano
Heckel Road
McKees Rock, Pennsylvania 15136

St. Francis Medical Center
Sister M. Rosita Wellinger
45th Street Off Pennsylvania Avenue
Pittsburgh, Pennysivania 15201

St. John's Health and Hospital Center
Harold D. Sanders
3339 McClure Avenue
Pittsburgh, Pennsylvania 15212

St. Margaret Memorial Hospital
Stanley J. Kevish
815 Freeport Road
Pittsburgh, Pennsylvania 15215

Sewickley Valley Hospital
Donald W. Spalding
Blackburn Road
Sewickley, Pennsylvania 15143

*Shadyside Hospital
5230 Centre Avenue
Pittsburgh, Pennsylvania 15232

*Hospitals that received telephone requests.

*South Hills Health System
George H. Yeckel
Coal Valley Road
Pittsburgh, Pennsylvania 15025

South Side Hospital
R. Timothy Stack
2000 Mary Street
Pittsburgh, Pennsylvania 15203

Southwood Psychiatric Hospital
Alan Axelson, M.D.
2575 Boyce Plaza Road
Pittsburgh, Pennsylvania 15241

Suburban General Hospital
John B. Mallon
South Jackson Avenue
Pittsburgh, Pennsylvania 15202

Podiatry Hospital of PGH
Joan Abaray
215 South Negley
Pittsburgh, Pennsylvania 15206

Rehabilitation Institute of Pittsburgh
John A. Wilson
6301 Northumberland Street
Pittsburgh, Pennsylvania 15217

*St. Clair Memorial Hospital
Benjamin E. Snead
1000 Bower Hill Road
Pittsburgh, Pennsylvania 15243

Children's Hospital of PGH
Edwin Zechman
125 DeSoto Street
Pittsburgh, Pennsylvania 15213

Eye and Ear Hospital of PGH
David Goff
230 Lothrop Street
Pittsburgh, Pennsylvania 15213

Magee-Womens Hospital
Geoffrey Suszkowski
Forbes and Halket Street
Pittsburgh, Pennsylvania 15213

Montefiore Hospital
Irwin Goldberg
3459 Fifth Avenue
Pittsburgh, Pennsylvania 15213

Presbyterian University Hospital
DeSota at O'Hara Streets
Pittsburgh, Pennsylvania 15213

Western Psychiatric Institute and Clinic
3811 O'Hara Street
Pittsburgh, Pennsylvania 15213

Watson D.T. Hospital for Children
Steven J. Mozolak
Camp Meeting Road
Sewickley, Pennsylvania 15143

West Allegheny Hospital
Gary Perecko
7777 Steubenville Pike
Oakdale, Pennsylvania 15071

West Penn Hospital
Steven A. Caywood
4800 Friendship Avenue
Pittsburgh, Pennsylvania 15224

Woodville State Hospital
Suzanne Kreinbrook, M.D.
Woodville Road
Carnegie, Pennyslvania 15106-3793

*Hospitals that received telephone requests.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

NOV 1 0 1986

In Reply Refer To: 10A431

Honorable Frank H. Murkowski
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

On April 10, 1986, you requested that the Veterans Administration investigate the potential acquisition through lease or purchase of an existing hospital as an alternative to new construction in Augusta, Georgia; Baltimore, Maryland; Palm Beach County, Florida; and Pittsburgh, Pennsylvania.

On June 16, 1986, I informed you in the case of Baltimore and Palm Beach County, no existing facilities have indicated an interest in lease or sale. This continues to be the case for both locations. The Veterans Administration continues to believe that funding for a new Baltimore facility in FY 1987 is appropriate. Planning for Palm Beach County will continue with budget considerations in the future.

Enclosed is a report on our findings on the two medical centers, one located in Oakdale, Pennsylvania, and the other in Augusta, Georgia, that expressed an interest in selling their facilities to the Veterans Administration as an alternative to constructing new replacement medical centers. As indicated by the reports, we have concluded that the Government will save money by proceeding with the replacement Veterans Administration medical center projects in both instances.

A similar letter has been forwarded to Senator Cranston and Representatives Montgomery and Hammerschmidt.

Your interest in this matter is appreciated.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosures

"America is #1—Thanks to our Veterans"

Evaluation of Purchase/Lease Alternative

West Allegheny Hospital
Oakdale, Pennsylvania

I. Purpose:

In response to a request of the Chairman, Senate Committee on Veterans' Affairs, the VA invited existing hospitals in the Pittsburgh, Pennsylvania, area to express their interest in selling to the VA. In response to such an expression, officials of the Department of Medicine and Surgery and the Office of Construction conducted a survey of the West Allegheny Hospital on June 12, 1986. The purpose of the survey was to review the facilities of West Allegheny Hospital and to determine the general condition and suitability as a potential alternative to the construction of a replacement hospital for the long term care division (Aspinwall) of the VA Medical Center in Pittsburgh, Pennsylvania.

II. Background:

1. West Allegheny Hospital

West Allegheny Hospital is a not-for-profit 94-bed general acute care facility located in Oakdale, Pennsylvania, approximately 11 miles west of downtown Pittsburgh. Built in 1973 to replace the facility used by the hospital since 1956, the 6-level structure provides approximately 100,000 usable square feet set on a 20.15-acre tract. Since its construction in 1973, approximately $2.0 million has been expended on equipment and interior and exterior improvements, including landscaping, new carpeting, wall and ceiling coverings and physical improvements in the lobby, admissions, and emergency areas.

2.

The West Allegheny Hospital cannot provide the 400 beds required by VA. The hospital consists of 3 nursing floors of 31 beds per floor. The 6th, or top floor, is "roughed-in" and could provide an additional 31 beds. If the square footage required for the Nursing Home Care Unit is subtracted, the VA requirement is 112,446 new square feet. If VA were to acquire the facility, it is felt that the most effective use of West Allegheny would be to renovate the existing structure for the required 160 intermediate beds and their support, and to construct a new 240-bed NHCU on the site. This would be 12,446 feet less than the required VA space criteria, however, it would be possible to meet the needs of the intermediate patient load. However, it would require extensive renovation on every floor and a total redesign of the 2nd floor. With placement of 31 beds in the unfinished 6th floor and the conversion of the 2nd floor to a nursing unit, a total of 155 beds would be realized. This is 5 beds less than the current MEDIPP bed projections which would be required in the renovation of the existing facility. Existing functions at Aspinwall that were not affected by the replacement hospital project must be accommodated at West Allegheny. These functions include the main administration building and a warehouse structure. The warehouse is the depot for both Aspinwall and University Drive. This additional square footage amounts to approximately 105,000 net square feet. The total number of new square feet necessary to relocate the Aspinwall facility is 440,402. There is enough

3.

acreage at West Allegheny to accommodate the necessary construction that would be required to meet the additional 340,000 net square feet. In summary, West Allegheny could be functionally adapted to meet our needs, if:

- A 240-bed NHCU is constructed.
- Warehouse and support facilities are constructed.
- Extensive renovation to the existing building is accomplished.
- Some reduction in VA criteria.

2. VA Medical Center, Pittsburgh (Aspinwall Division)

This predominantly intermediate and long term care 431-bed hospital is located approximately 7 miles northeast of downtown Pittsburgh. Except for a 29,928 square foot warehouse, newly constructed 18 months ago, all occupied buildings are in excess of 60 years old. All buildings have life safety code violations with inadequate provisions for handicapped patients. Nursing units are not air conditioned and suffer from a lack of privacy. The campus-like setting contains 37 major structures, virtually all of brick masonry construction. The buildings are spread throughout the site and occupy most of the site on which construction take place. The entire property is eligible for listing on the National Register of Historic Places.

The estimated fair market value of the West Allegheny property is $11,718,842. It was arrived at by adding the current fair market value of the land to the cost of reproducing the hospital building new, less an allowance for accrued depreciation resulting from age and condition. The cost to the Veterans Administration would be this estimated fair market value purchase cost, plus the estimated cost of (1) additions and renovations which would be needed to produce a 400-bed VA facility at this location, (2) the construction required to reproduce space for those functions currently located at VAMC Aspinwall that would need to be relocated, (3) additional energy facilities, and (4) site work and parking. The total price is estimated to be $59,304,842, to duplicate these VA facilities at the West Allegheny site.

III. Evaluation and Cost Comparison:

A feasibility study comparison of the estimated cost to construct the replacement VA medical facility on the Aspinwall property versus the estimated cost to purchase the West Allegheny Hospital, modify the site, construct the necessary additions, and complete the renovations of that existing structure that would be required to bring it up to VA health care standards is listed below:

5.

1.	Total Estimated Cost of Replacement Medical Facility at VAMC Aspinwall		$52,851,000
2.	Total Estimated Cost to Purchase and Modify West Allegheny Hospital Property for VA Use		$59,304,842
	Market Value Price of West Allegheny Hospital Building (Including Physical Plant and All Improvements on Site)	$11,018,842	
	Market Value Price of 20.15 Acre Site	$ 700,000	
	New Boiler/Energy Plant	$ 8,108,000	
	New Construction to Provide Medical Space Equivalent to VAMC Aspinwall Replacement Project	$24,846,000	
	Renovation and Alteration of Existing Hospital Building	$10,394,000	
	New Replacement Warehouse	$ 2,040,000	
	Utilities	$ 748,000	
	Site Work	$ 1,450,000	

6.

IV. Conclusions:

The estimated cost to construct the replacement VAMC at Aspinwall is $52,851,000. The estimated cost to purchase and modify the West Allegheny hospital property for VA requirements, including the offset cost for excessing the VAMC Aspinwall property is $59,304,842. Therefore, the Government would save approximately $6,454,000 by proceeding with the replacement VAMC project at Aspinwall.

Evaluation of Purchase/Lease Alternative

St. Joseph Hospital
Augusta, Georgia

I. Purpose:

In response to a request of the Chairman, Senate Committee on Veterans' Affairs, the VA invited existing hospitals in the Augusta, Georgia, area to express their interest in selling to the VA. In response to such an expression, officials of the Department of Medicine and Surgery and the Office of Construction conducted a survey of the St. Joseph Hospital on June 26, 1986. The purpose of the survey was to review the facilities of St. Joseph Hospital and to determine the general condition and suitability as a potential alternative to the construction of a replacement hospital for the long term care division (Uptown) of the VA Medical Center in Augusta, Georgia.

II. Background:

1. St. Joseph Hospital

St. Joseph Hospital is an acute medical and surgical hospital located at 2260 Wrightsboro Road, Augusta, Georgia, 30910. The hospital is operated under the auspices of the Sisters of St. Joseph of Carondelet located in St. Louis, Missouri. The hospital, sited on approximately 24 acres, consists of the main hospital building and a professional village which contains 12 primarily 1 story buildings for doctors suites. The hospital is typical of most hospitals in that it has undergone a number of additions and renovations. The original facility was constructed in 1950 and activated in December 1952.

2.

This portion of the hospital is now mainly used for office space with the exception of a 9-bed ICU/CCU. Basically, the hospital operates 235 beds and is licensed for 240 beds. The physical plant capacity is 261 beds. The hospital has undergone three additions as follows:

- The Trinity Wing constructed in 1979 and completed in 1982 consisted of four floors and provided 99 private rooms with bath.

- The Madonna Wing constructed in 1961 and completed in 1967 consisted of 3 floors and provided 77 beds; 45 private and 27 semi-private.

- In 1969, construction started on a 4th floor addition to the Madonna Wing which was completed in 1972. This addition provided 51 beds; 6 semi-private and 45 private rooms.

The latest renovation was started in 1984 and completed in March 1986. This renovation involved a new Medical Records area, Pharmacy, Respiratory and Cardiovascular area, Day Surgery, Nuclear Medicine, Blood Bank, Outpatient Registration, additional X-Ray rooms and replacement of the CT Scanner.

St. Joseph's has purchased land west of the city of Augusta in an adjacent county. The new land is in an area where most of the development from Augusta is taking place. St. Joseph's current plan is to construct a new hospital in this western suburb. They anticipate their existing hospital will be made available in 4 to 4 1/2 years to any prospective buyer.

3.

2. The VA proposes to correct present deficiencies at the Augusta (Uptown Division), Georgia, Medical Center through the replacement of most of the existing facility's buildings. Buildings 19 and 20 will remain and will continue in use for administrative functions. Building 18 will remain and be renovated for temporary housing of an alcohol treatment ward during construction of the replacement medical center. Building 96 will be retained as the laundry, and Building 82 will be retained for dietetics. New construction will consolidate the outpatient and clinical support functions. The inpatient beds will be consolidated directly above the outpatient and clinical support facilities. The bed level, with all beds being located in new construction, for the replacement medical center will be: 340 psychiatric, 70 alcohol, 180 intermediate, 60 nursing home care (NHC). This reflects a reduction of 132 hospital and an increase of 20 NHC beds in the current authorized bed level, or a total of 650 beds.

The 1995 parking analysis shows a need for 912 parking spaces. Considering the existing spaces, this results in a deficit of 225 parking spaces. The project will provide approximately 920 parking spaces, including the 663 spaces displaced by new construction.

Demolition of Buildings 1 through 8, 12, 13, 14, 21, and eventually 34, will require compliance with the National Historic Preservation Act of 1966, Section 106. The structures will be recorded as required and coordination will occur with both the State and Federal authorities. The potential for a determination of adverse effect does exist in relation to the removal of Building 34. If a determination of adverse effect does result, the VA will be required to negotiate a mitigation plan before Building 34 is demolished.

An environmental assessment was accomplished with a finding of no significant impact and was published in the Federal Register on May 27, 1983.

3. The St. Joseph's Hospital cannot provide for the 590 hospital and 60 nursing home care beds required by VA. There is enough acreage at St. Joseph's to accommodate the necessary construction that would be required to meet the VA's need, however, there would be no outside recreation areas for patient use. The St. Joseph's Hospital consists of 309,739 gross square feet located on 24.3 acres of land. The VA's program provides for 800,000 GSF located on 105 acres of land. Portions of the VA site that are not considered in the replacement VA project but which would have to be included in the St. Joseph site are: administration building, a centralized laundry which provides service to 5 VA hospitals (Atlanta, Augusta, and Dublin, Georgia, and Charleston and Columbia, South Carolina) an energy plant and Dietetics (food preparation and distribution for both Augusta VA divisions). In summary, we would have to renovate approximately 225,000 GSF and construct new space of approximately 500,000 GSF.

5.

Due to the limited time allowed for the evaluation of St. Joseph Hospital, Augusta, and VAMC Uptown Division in Augusta, only a market evaluation has been developed. Extensive time and expense would be required to obtain a fair market value appraisal of these hospitals by contract with a fee appraiser qualified to appraise this type of property.

The Uptown Division is a 639-bed long term psychiatric facility located on 105 acres with 40 buildings built primarily between the years 1912 and 1931 with some buildings and additions added as late as 1981. The 236-bed St. Joseph facility, located approximately 4 blocks east of the Uptown Division, is a general medical and surgical short term facility situated on approximately 24.3 acres with one main building and a small clinic building, built in 1950 and opened in 1952, with some expansion as recent as 1979 and 1982. Due to the vast difference between the two facilities it is not feasible to make a strict comparison of the two for this market evaluation.

The land uses in the immediate area of both St. Joseph and the Uptown Division are of a varied nature with single family residential being the predominant use with some light commercial use. The area in which the VAMC is located is on the lower socio-economic end of the scale, the St. Joseph area appears to be on a higher socio-economic scale. The immediate area surrounding the Uptown Division and St. Joseph appears to be in the midst of a transition. Growth in the Augusta area is taking

6.

place in the northern and western regions located in the adjoining Columbia County rather than in the subject Richmond County where these hospital facilities are located.

It should be noted that St. Joseph Hospital has already purchased an option on 40 acres of land in the growing Columbia County Area for $30,000 an acre. St. Joseph Hospital intends to sell the subject location in Augusta to offset the building of the new facility.

Information regarding the health facility sales was obtained from the State of Georgia Health Planning Agency and several recent hospital sales were located within the State that could be used for this market evaluation. Due to the limited time allowed for this study only certain locations, number of beds, size, type of medical facility, medical speciality and percentage of occupancy could be evaluated.

There was one sale of a hospital in Augusta to Humana Corporation in recent years that was not considered in this overview because according to our inquiry of Humana Corporation, the facility was purchased in a corporate merger with American Medico, Inc. with 39 other hospitals. The price paid did not appear to coincide with the market prices for similar hospitals.

Based on a thorough evaluation of the above information it was determined that hospitals similar to St. Joseph are currently selling within a range of $13 million to $15 million in the State of Georgia. Since the St. Joseph's Hospital will not be available for 4-5 years, our final acquisition cost is estimated at $20 million. This cost includes 5 percent escalation per year for five years.

III. Evaluation and Cost Comparisons:

A feasibility study comparison of the estimated cost to construct the replacement VA medical facility on the Augusta property versus the estimated cost to purchase the St. Joseph's Hospital, modify the site, construct the necessary additions, and complete the renovations of that existing hospital structure that would be required to bring it up to VA health care standards is listed below:

1.	Total Estimated Cost of Replacement Medical Facility at VAMC Augusta, Georgia		$ 97,000,000
2.	Total Estimated Cost to Purchase and Modify St. Joseph's Hospital for VA Use		$128,067,000
	Total Estimated Cost to Purchase St. Joseph Hospital and Property for VA Use	$ 20,000,000	
	New Addition to Provide Needed Bed, Clinical, Laundry and Dietetic Space	$ 66,114,000	
	Renovation and Alterations of Existing Hospital Building	$ 23,313,000	
	Parking Structure for 900 Cars	$ 9,606,000	
	Energy Plant	$ 4,931,000	
	Seismic Corrections and Site Work	$ 4,103,000	

IV. Conclusions:

The estimated cost to construct the replacement VA hospital at Augusta, Georgia, is $97,000,000. The estimated cost to purchase and modify the St. Joseph's Hospital property for VA requirements, including the offset cost for excessing the VAMC Augusta, Georgia, property is $128,067,000. Therefore, the government would save approximately $31,067,000 by proceeding with the replacement project at Augusta, Georgia.

DRAFT PROSPECTUSES

Construction, Major Projects
VAMC Atlanta, Georgia
Clinical Addition, Parking Garage, and Seismic Strengthening

I. Budget Authority

Total Estimated Cost	Available Thru 1986	1987 Request	1988 or Future
$77,500,000	...	$ 7,800,000*	$69,700,000

* Funds being requested in 1987 are for design only.

II. Description of Project

This project proposes to correct major space and functional deficiencies through new construction and alterations of the main hospital building. Approximately 50 percent of the Medical Center will be upgraded and expanded to provide adequate space. Medical services are to be realigned to enhance operational efficiency in terms of staff utilization, patient flow, and material distribution. The project will include such major services and their associated support functions such as laboratory, radiology, surgery, and cardiology. In addition the project will include all intensive care units.

Other requirements included in the project are the seismic reinforcement of the existing main hospital building and the connecting corridors from the existing hospital structure to the new addition and the existing nursing home care unit. The 1995 parking analysis shows a need for 1,390 parking spaces. Considering the existing spaces, this results in a deficit of 813 spaces. A parking garage of approximately 800 spaces (450 parking spaces will be lost due to construction) and realignment of site circulation are included in the project.

An environmental assessment was accomplished with a finding of no significant impact and was published in the Federal Register on May 3, 1984.

III. Justification for Project

Most of the functions and services included in this project are significantly deficient in space, configuration, departmental relationships, and various accreditation requirements. The Medical Center was activated in 1966 and, since activation, the number of patients, the range of services, and sophistication of medical care has increased substantially. Despite these increases, only limited improvements or expansion of space have taken place. Space deficiencies are extreme for many clinical services and support functions and the average deficiency o, those included in this project is 47 percent. Departmental layouts are generally compromised by poor workflow, inadequate waiting, privacy, storage, and other support elements. In some instances, actual fragmentation of the departments exists. Functional relationships between many critical areas, such as surgery, intensive care units, and diagnostic services are seriously inadequate, resulting in inefficient operations. Travel times and distances for patients, staff, visitors, and material distribution are excessive.

The Medical Center site is fully utilized by buildings or existing parking. Construction of the new clinical addition will displace approximately 450 spaces. Consequently, a parking structure is essential to meet the projected requirements. The new parking garage and realignment of site circulation will allow reasonable proximity and access for patients, staff, visitors, and services to the Medical Center.

This project, with appropriate sizing, location, and configuration of services, interconnection of buildings, improved circulation, and correction of seismic deficiencies will provide a complete, modern health care facility.

This project is intended to resolve space and functional deficiencies created by new services, associated support functions, and an increased outpatient workload at this Medical Center. Additional resources will be required to meet increased demand for inpatient and outpatient care, and to maintain and care for more sophisticated medical equipment and treatment modalities. Cost avoidance may occur due to more energy efficient construction, and other design and construction improvements, but is difficult to document and not obtainable.

IV. Background

There were three alternatives developed for this project. All alternatives involved the same services and functions. Differences exist in the amount of new construction versus renovation with the total amount of construction and cost remaining relatively constant. Significant differences, and the basis for selection, are related to the arrangement of functional areas and circulation. The functions to be included on Floors 7, 10, and 11 (existing hospital building), which will be renovated for beds, is the same in all alternatives.

Construction, Major Projects
VAMC Atlanta, Georgia
Clinical Addition, Parking Garage, and Seismic Strengthening

Alternative 1: This alternative would provide functions as follows: Ground Floor - surgical suite, surgical intensive care unit, laboratory, and radiation therapy; First Floor - audiology and speech pathology, canteen, dialysis, nuclear medicine, prosthetics, radiology, rehabilitation medicine, and administrative offices; and, Second Floor - cardiology, chaplain, coronary care unit, dietetics, medical intensive care unit, and research.

Alternative 2: This alternative would provide functions as follows: Ground Floor - laboratory, radiation therapy, and research; First Floor - surgical suite, surgical intensive care unit, audiology and speech pathology, canteen, nuclear medicine, and radiology; and, Second Floor - cardiology, coronary care unit, dietetics, medical intensive care unit, prosthetics, recreation, rehabilitation medicine, and administrative offices.

Alternative 3: This alternative would provide functions as follows: Ground Floor - audiology and speech pathology, dialysis, dietetics, autopsy, pharmacy, and radiation therapy; First Floor - canteen, chaplain, nuclear medicine, prosthetics, radiology, recreation, and rehabilitation medicine; Second Floor - cardiology, coronary care unit, laboratory, surgical suite, and surgical intensive care; Third Floor - administrative offices; and, Fourth and Fifth Floor - research.

All alternatives were developed using the following current and 1995 projected workloads.

	Current	Projected
Beds	450	692*
Outpatient visits	145,774	187,900

*Projected increase reflects future neurology, psychiatric, medical, and surgical beds.

Alternatives 1 and 2 were rejected because, although space requirements would have been met, the functional relationships between medical services would have been unacceptable. The location of the services would have had an adverse effect on the circulation patterns of patients and staff. These alternatives would have been less effective operationally. These alternatives in addition would have consumed more site and involved difficult phasing.

Alternative 3 was selected because it would provide the best use of space, functional adjacencies, internal circulation, site circulation, and future flexibility.

V. Correction of Code Deficiencies

New construction and renovation within this project will be accomplished in accordance with all National Fire Protection Association, Joint Commission on Accreditation of Hospitals, and handicapped accessibility codes and requirements.

VI. Schedule

Complete preliminary plans	09/10/86
Complete construction	06/11/91

Construction, Major Projects
VAMC Atlanta, Georgia
Clinical Addition, Parking Garage, and Seismic Strengthening

VII. Project Cost Summary

			Cost
New Construction	280,000 gross square feet @ $108.64		$30,420,000
Alterations	177,000 gross square feet @ $ 85.13		15,100,000
Subtotal (new construction and alterations)			$45,520,000
Other Costs:			
a. Sitework, utilities, demolition and surface parking		$ 1,580,000	
b. Parking structure (310,000 gross square feet)		7,750,000	
c. Addition to chiller building and 1,000 ton chillers		1,000,000	
d. Seismic strengthening		2,700,000	
Total Other Costs		$13,030,000	13,030,000
Total Estimated Base Construction Cost			$58,550,000
Construction Contingency (6 percent)		3,900,000	
SBA(8a) Allowance		N/A	
Contingency Reserve		3,900,000	3,900,000
Technical Services (7.5 percent)			4,900,000
Impact Costs			3,500,000
Utilities Agreement			150,000
Total Estimated Base Cost			$71,000,000
Inflation Allowance			6,500,000
Total Estimated Project Cost			$77,500,000

VIII. Annual Operating, Staff and Equipment Cost

	Project Activation Costs		Present Facility Operating Costs	
Equipment cost		$16,000,000		N/A
One time non-recurring cost		2,100,000		N/A
Recurring costs:				
Additional manpower	FTE: 237	$6,873,000	FTE: 1390	$40,577,248
Other recurring		1,500,000		18,836,012
Total recurring		$8,373,000		$59,413,260

IX. Executive Order 12372 Compliance

The VA notified State and Areawide Clearinghouses on October 10, 1980. Favorable replies were received from both clearinghouses.

Construction, Major Projects
VAMC Hampton, Virginia
112-bed Nursing Home Care Addition

I. Budget Authority

Total Estimated Cost	Available Thru 1986	1987 Request	1988 or Future
$6,500,000	...	$6,500,000	...

II. Description of Project

This project proposes to construct a second floor 112-bed nursing home care (NHC) addition to the existing 120-bed NHC unit, Building 146. Construction of the additional floor will necessitate modifications to the existing facility including a reduction of eight beds, changes to support areas, and installation of elevators. Modifications will be necessary to the Dietetics Building 116 to install a tray make-up line and support areas for the entire nursing home. When completed, the NHC building will house 224 beds.

Compliance with the National Historic Preservation Act of 1966, Section 106, will be necessary. An environmental assessment was accomplished with a finding of no significant impact and was published in the Federal Register on December 31, 1985.

III. Justification for Project

There are currently 382 VA-owned and operated nursing home care beds in Medical District 7. There are currently 52 community nursing home beds being utilized by VA patients from this facility. Medical District Initiated Program Planning (MEDIPP) projects that, by 1995, the total need for VA nursing home care beds for this medical district will be 680. This project proposes to increase the number of nursing home care beds at this Medical Center from 120 to 224 beds.

The documentation of the number of VA beds needed required an assessment of the availability of community and state nursing home beds for VA patients and the feasibility of converting or renovating existing VA space into nursing home care units. This determination is made through the MEDIPP process and considers state projections of growth in the nursing home industry and state moratoriums on new construction, community nursing home occupancy rates, geographic dispersion of vacant beds, and whether community facilities meet VA fire and safety codes and VA criteria for community nursing home acceptance of VA patients.

The primary reason for this project is to provide the number of additional beds the Medical District plan determined as needed at this Medical Center. Additional resources will be required to meet the increased demand of nursing home care patients. Cost avoidance may occur due to more energy efficient construction, and other design and construction improvements, but is difficult to document and not obtainable.

IV. Background

Buidling 146, completed in 1980, was designed for future expansion for nursing home care beds. Consequently no alternatives other than to construct a second floor to the existing 120-bed NHC building were developed.

V. Correction of Code Deficiencies

The addition to the nursing home care building will be totally new construction, designed and constructed to meet all current code requirements.

VI. Schedule

Complete preliminary plans	04/28/86
Complete construction	05/30/89

Construction, Major Projects
VAMC Hampton, Virginia
112-bed Nursing Home Care Addition

VII. Project Cost Summary

			Cost
New Construction	47,618 gross square feet @ $96.71		$4,605,000
Alterations	4,210 gross square feet @ $30.00		126,000
Subtotal (new construction and alterations)			$4,731,000
Other Costs:			
a. Sitework, utilities, demolition and surface parking		$ 8,000	
Total Other Costs		8,000	8,000
Total Estimated Base Construction Cost			$4,739,000
Construction Contingency (5 percent)		237,000	
SBA(8a) Allowance (8 percent)		379,000	
Contingency Reserve		616,000	616,000
Technical Services (7.5 percent)			402,000
Impact Costs			165,000
Utilities Agreements			5,000
Total Estimated Base Cost			$5,922,000
Inflation Allowance			578,000
Total Estimated Project Cost			$6,500,000

VIII. Annual Operating, Staff and Equipment Cost

	Project Activation Costs		Present Facility Operating Costs	
Equipment cost		$700,000		N/A
One time non-recurring cost		572,000		N/A
Recurring costs:				
Additional manpower	FTE: 109	$3,161,000	FTE: 1255	$33,133,054
Other recurring		837,000		10,709,408
Total recurring		$3,998,000		$43,842,462

IX. Executive Order 12372 Compliance

The State's single point of contact was notified August 28, 1985. No response has been received to date.

Construction, Major Projects
VAMC Huntington, West Virginia
Clinical Improvement Addition

I. Budget Authority

Total Estimated Cost	Available Thru 1986	1987 Request	1988 or Future
$48,000,000	...	$48,000,000	...

II. Description of Project

This project proposes to renovate certain areas of the main hospital, Building I, and construct a basement and six-story addition south of Building I. Services to be included in the new addition and renovated space are surgical operating suite, medical and surgical nursing units, medical and surgical intensive care units, ambulatory care clinic including medical administration support, eye clinic, audiology and speech pathology clinic, dialysis center, and alcohol and drug dependence clinics. Supporting services to be included are laboratory, radiology, cardiology, nuclear medicine, respiratory care, and prosthetics and sensory aids. A warehouse to include supply processing and distribution (SPD) center and administrative space for the Director's suite, personnel, nursing, supply, engineering, social work, chaplain, and voluntary services will be provided. Two new medical nursing units and one medical nursing unit converted to a psychiatric nursing unit will be provided under this project.

Heating, ventilation, and air conditioning of the new addition as well as air conditioning of Building I is planned.

The 1995 parking analysis shows a need for 1,165 parking spaces. Considering the existing spaces, this results in a deficit of 492 spaces. A new 500-car parking structure is proposed to be constructed as part of this project.

Compliance with the National Historic Preservation Act of 1966, Section 106, will be necessary. An environmental assessment is being accomplished and the results will be published in the Federal Register in the near future.

III. Justification for Project

Serious space and functional deficiencies exist for outpatient, radiology, laboratory, and surgical services. Space and functional deficiencies are evident in surgical and medical nursing units as well as needed space for a psychiatric nursing unit. Severe space constraints prevent an effective layout of patient and support services in the existing buildings, particularly in ambulatory care and medical administration services. The services included in this project will be expanded, upgraded, and realigned to eliminate space and functional deficiencies.

This project is intended to resolve space and functional deficiencies created by new services, associated support functions and an increased outpatient workload at this Medical Center. Additional resources will be required to meet increased demand for inpatient and outpatient care, and to maintain and care for more sophisticated medical equipment and treatment modalities. Cost avoidance may occur due to more energy efficient construction, and other design and construction improvements, but is difficult to document and not obtainable.

IV. Background

There were three alternatives developed for this project. All alternatives include air conditioning of the nursing units in Building I and a 500-car parking structure.

> Alternative 1: This alternative would provide a three-story addition north of Building 12 and a basement and five-story addition on the south side of Building I. Buildings 12 and I would be modernized in selected areas.
>
> Alternative 2: This alternative would provide a basement and six-story addition to the rear of Building I, incorporating all functions. Buildings 12 and I would be modernized in selected areas.
>
> Alternative 3: This alternative would provide a basement and six-story addition to the rear of Building I and include modernization of selected areas of Buildings I and 12. In addition this alternative would relocate supply processing and distribution to the new addition. The space thus vacated would be converted for outpatient psychiatry and substance abuse clinics.

Construction, Major Projects
VAMC Huntington, West Virginia
Clinical Improvement Addition

All alternatives were developed using the following current and 1995 projected workloads.

	Current	Projected
Beds	180	255 (includes 5 dialysis beds)
Outpatient visits	48,804	75,300

Alternative 1 was rejected because it would have required new construction in front and behind the hospital due to the limited land available on the site. Outpatient psychiatry would have been located on the sixth floor. The SPD connection to the surgical operating rooms would have been unsatisfactory.

Alternative 2 was rejected because, although it would have consolidated services into one new addition to the rear, it still would have left SPD and outpatient psychiatry in unsatisfactory relationships to other services.

Alternative 3 was selected because services would be consolidated into one new addition, with proper functional relationships being achieved. The SPD would be brought into the proper relationship with the surgical operating suite and outpatient psychiatry would be located on the ground floor adjoining the ambulatory care clinics. The medical nursing unit on the floor immediately above would be reassigned for psychiatric inpatients, thus consolidating all mental health activities in an area readily available to patients.

V. Correction of Code Deficiencies

New construction and renovation within this project will be accomplished in accordance with all National Fire Protection Association, Joint Commission on Accreditation of Hospitals, and handicapped accessibility codes and requirements.

VI. Schedule

Complete preliminary plans	12/03/85
Complete construction	03/30/90

VII. Project Cost Summary

			Cost
New Construction	203,700 gross square feet @ $120.78		$24,603,000
Alterations	61,300 gross square feet @ $ 87.97		5,393,000
Subtotal (new construction and alterations)			$29,996,000
Other Costs:			
a. Sitework, utilities, demolition and surface parking		$1,535,000	
b. Parking garage (173,920 gross square feet)		4,674,000	
c. Air conditioning, sprinkler system retrofit		2,383,000	
Total Other Costs		8,592,000	8,592,000
Total Estimated Base Construction Cost			$38,588,000
Construction Contingency (6 percent)		2,315,000	
SBA(8a) Allowance		N/A	
Contingency Reserve		2,315,000	2,315,000
Technical Services (7.5 percent)			3,068,000
Impact Costs			500,000
Utilities Agreements			50,000
Total Estimated Base Cost			$44,512,000
Inflation Allowance			3,479,000
Total Estimated Project Cost			$48,000,000

VIII. Annual Operating, Staff and Equipment Cost

	Project Activation Costs		Present Facility Operating Costs	
Equipment cost		$9,600,000		N/A
One time non-recurring cost		1,600,000		N/A
Recurring costs:				
Additional manpower	FTE: 262	$7,598,000	FTE: 476	$13,249,192
Other recurring		2,000,000		7,388,804
Total recurring		$9,598,000		$20,637,996

Construction, Major Projects
VAMC Huntington, West Virginia
Clinical Improvement Addition

IX. Executive Order 12372 Compliance

The VA notified State and Areawide Clearinghouses on December 4, 1980. The State Clearinghouse replied on December 10, 1980, and the Areawide Clearinghouse on December 16, 1980, with no adverse comments.

Construction, Major Projects
VAMC Knoxville, Iowa
Laundry Replacement

I. Budget Authority

Total Estimated Cost	Available Thru 1986	1987 Request	1988 or Future
$4,500,000	...	$4,500,000	...

II. Description of Project

This project proposes to provide a consolidated replacement laundry building and equipment system to serve the Medical Centers at Knoxville, Iowa City, and Des Moines which have a projected workload of 3.8 million pounds annually. The building will follow a prototypical design and will be located on the Knoxville Medical Center site adjacent to the boiler plant, Building 77. Vehicle access and clean and soiled loading docks will be provided to handle semi-trailers transporting linen to the Medical Centers at Iowa City and Des Moines.

Compliance with the National Historic Preservation Act of 1966, Section 106, will be necessary. An environmental assessment is being accomplished and the results were published in the Federal Register on October 30, 1985.

III. Justification for Project

The existing laundry supports the Medical Centers at Knoxville and Iowa City and is housed in a structure that was constructed in 1923. The building is too small to handle the present workload and soiled linen is consequently stored in a separate unheated building. Serious functional and spacial, as well as accreditation, life safety, and building systems, deficiencies exist.

The current Medical District plans project the consolidation of the laundry workload from Des Moines. This consolidation cannot occur without a laundry expansion at Knoxville. The consolidation is planned to avoid the cost involved with modernization of the Des Moines laundry and to achieve a staffing reduction of six laundry employees amongst the three Medical Centers.

This project will correct these space and functional deficiencies by providing a new facility designed specifically to accommodate efficient modern equipment. With this project staffing can be reduced by 6 FTE.

IV. Background

In compliance with OMB Circular A-76, a study has been completed and the determination has been made that adequate commercial sources do not exist for contracting out the existing nor projected workload. In compliance with OMB Circular A-104, the VA has determined that no acceptable facilities to provide a laundry building exist within the service area for lease or purchase. Therefore the only viable option was to provide for a consolidated laundry on the Medical Center site. The possibility of renovating and expanding the existing laundry building was considered and it was determined that the age and constraints of the existing building would make this impractical. New construction was considered to be the most effective solution. Available sites on the Medical Center property were considered to determine the most appropriate location.

Alternative 1: This site would be west of the water tower.

Alternative 2: This site would be south of Building 81.

Alternative 3: This site would be north of Building 66.

Alternative 1 was rejected because it would have adversely impacted on the recreational and rehabilitation golf facility, would have constricted vehicle access, and would have been some distance from the steam plant.

Alternative 2 was rejected because it would have placed the laundry among patient treatment buildings and would have been some distance from the steam plant.

Alternative 3 was selected because it would be located adjacent to the steam plant, have good vehicle access and place the laundry operation among the Medical Center's industrial activities.

Construction, Major Projects
VAMC Knoxville, Iowa
Laundry Replacement

V. Correction of Code Deficiencies

The new laundry will be in compliance with National Fire Protection Association, and Joint Commission on Accreditation of Hospitals codes and requirements. It will replace an existing laundry which does not meet codes and standards, and is functionally inadequate to meet current and projected demand and workload.

VI. Schedule

Complete preliminary plans	10/15/85
Complete construction	12/22/89

VII. Project Cost Summary

		Cost
New Construction 18,035 gross square feet @ $78.00		$1,407,000
Alterations		N/A
Subtotal (new construction and alterations)		$1,407,000
Other Costs:		
a. Sitework, utilities, demolition and surface parking	$215,000	
b. Laundry Equipment Installation	326,000	
Total Other Costs	541,000	541,000
Total Estimated Base Construction Cost		$1,948,000
Construction Contingency (5 percent)	97,000	
SBA(8a) Allowance (8 percent)	156,000	
Contingency Reserve	253,000	253,000
Technical Services (Testing)		36,000
Laundry Equipment		1,960,000
Total Estimated Base Cost		$4,197,000
Inflation Allowance		303,000
Total Estimated Project Cost		$4,500,000

VIII. Annual Operating, Staff and Equipment Cost

	Project Activation Costs		Present Facility Operating Costs	
Equipment cost		$ 50,000		N/A
One time non-recurring cost		200,000		N/A
Recurring costs:				
Additional manpower	FTE: 0	$ 0	FTE: 992	$24,733,547
Other recurring		150,000		5,238,015
Total recurring		$150,000		$29,971,562

IX. Executive Order 12372 Compliance

The VA notified State and Areawide Clearinghouses on January 8, 1981. A favorable response was received from the Areawide Clearinghouse. No response was received from the State Clearinghouse.

Construction, Major Projects
VAMC Marion, Indiana
240-bed Nursing Home Care Unit

I. Budget Authority

Total Estimated Cost	Available Thru 1986	1987 Request	1988 or Future
$12,800,000	...	$12,800,000	...

II. Description of Project

This project proposes to construct a new 240-bed nursing home care (NHC) unit located southeast of Buildings 15, 16, and 17. The new construction will be based on the prototype NHC unit design, and it will include all necessary electrical and mechanical systems required to provide a completely operational facility. The existing 69 NHC beds at this Medical Center will be incorporated into this project's 240 beds and the vacated space will be backfilled by a proposed future project involving laboratory, dental, and podiatry services and a 30-bed acute medical nursing unit. The site on which the NHC unit will be built was excessed by the VA in 1970 and donated to the City of Marion for use as a park. The City has agreed to transfer the land back to the VA.

The 1995 parking analysis shows a need for 588 parking spaces. Considering the existing spaces, this results in a surplus of 260 spaces. All associated site work, including 140 parking spaces, will be included in the scope of the project. Although a surplus will exist, the additional parking is necessary to provide acceptable access and proximity to the NHC unit.

Compliance with the National Historic Act of 1966, Section 106, will be necessary. The Environmental Review Board approved the environmental assessment on December 5, 1984. A finding of no significant impact will be published in the Federal Register in the near future.

III. Justification for Project

The Medical Center currently has an authorized capacity of 69 nursing home care beds. The Medical Center has significant space, functional, and patient privacy deficiencies in the existing NHC unit.

There are currently 363 VA-owned and operated nursing home care beds in Medical District 15. There are currently 85 community nursing home beds being utilized by VA patients from this facility. Medical District Initiated Program Planning (MEDIPP) projects that, by 1995, the total need for nursing home care beds for this medical district will be 720. This project proposes to increase the number of nursing home care beds at this Medical Center from 69 to 240 beds.

The documentation of the number of VA beds needed required an assessment of the availability of community and state nursing home beds for VA patients and the feasibility of converting or renovating existing VA space into nursing home care units. This determination is made through the MEDIPP process and considers state projections of growth in the nursing home industry and state moratoriums on new construction, community nursing home occupancy rates, geographic dispersion of vacant beds, and whether community facilities meet VA fire and safety codes and VA criteria for community nursing home acceptance of VA patients.

There are 4,345 existing community nursing home beds. Growth in the number of community beds is projected to be 2.8 percent annually while veteran utilization is expected to triple. This slow growth coupled with existing stringent community admission criteria restricts the number of community beds available for VA patients.

The primary reason for this project is to provide the number of additional beds the Medical District plan determined as needed at this Medical Center. Additional resources will be required to meet the increased demand of nursing home care patients. Cost avoidance may occur due to more energy efficient construction, and other design and construction improvements, but is difficult to document and not obtainable.

IV. Background

A site alternative, southeast of Buildings 15, 16, and 17, for the NHC unit has been selected. Although this site was selected prior to the inception of a comprehensive facility plan, it will be verified during the planning process. Alternative sites will also be evaluated during site concept development. The planning process will include concepts for a 154-bed psychiatric building or renovation of existing buildings.

Construction, Major Projects
VAMC Marion, Indiana
240-bed Nursing Home Care Unit

V. Correction of Code Deficiencies

The nursing home care building will be a totally new structure, designed and constructed to meet all current code requirements.

VI. Schedule

Complete preliminary plans	N/A
Complete construction	09/22/89

NOTE: As the nursing home care prototype is being used in the development of this project, there is no need for completed preliminary plans.

VII. Project Cost Summary

		Cost
New Construction 99,204 gross square feet @ $90.00		$ 8,928,360
Alterations		N/A
Subtotal (new construction and alterations)		$ 8,928,360
Other Costs:		
a. Sitework, utilities, demolition and surface parking	$1,215,000	
b. Emergency generator and switchgear building	75,000	
Total Other Costs	1,290,000	1,290,000
Total Estimated Base Construction Cost		$10,218,360
Construction Contingency (5 percent)	511,000	
SBA(8a) Allowance (8 percent)	818,000	
Contingency Reserve	1,329,000	1,329,000
Technical Services (Testing)		20,000
Utilities Agreements		50,000
Site Acquisition		67,000
Total Estimated Base Cost		$11,684,360
Inflation Allowance		1,115,6[illegible]
Total Estimated Project Cost		$12,800,000

VIII. Annual Operating, Staff and Equipment Cost

	Project Activation Costs		Present Facility Operating Costs	
Equipment cost		$1,400,000		N/A
One time non-recurring cost		1,070,000		N/A
Recurring costs:				
Additional manpower	FTE: 168	$4,872,000	FTE: 1244	$30,805,382
Other recurring		1,296,000		6,196,219
Total recurring		$6,168,000		$37,001,601

IX. Executive Order 12372 Compliance

The VA notified State and Areawide Clearinghouses on January 2, 1981. An acknowledgement was received from the Areawide Clearinghouse, with no comment. No response was received from the State Clearinghouse.

Construction, Major Projects
VAMC Mountain Home, Tennessee
120-bed Nursing Home Care Unit

I. Budget Authority

Total Estimated Cost	Available Thru 1986	1987 Request	1988 or Future
$7,700,000	...	$7,700,000	...

II. Description of Project

This project proposes to construct a new two-story 120-bed nursing home care unit (NHCU) located north of existing Building 37. The new construction will be based on the prototype NHC unit design, and it will include all necessary electrical and mechanical systems required to provide a completely operational facility. The existing 58 NHC beds at this Medical Center will be incorporated into this project's 120 beds and the vacated space will be backfilled by medical research by a future minor construction project.

The 1995 parking analysis shows a need for 1,064 parking spaces. Considering the existing spaces, this results in a surplus of 309 spaces. All associated site work, including 54 parking spaces specifically for the NHC unit, will be included in the scope of the project.

Compliance with the National Historic Preservation Act of 1966, Section 106, will be necessary. An environmental assessment was accomplished with a finding of no significant impact and was published in the Federal Register on March 18, 1983.

III. Justification for Project

The Medical Center currently has an authorized capacity of 58 nursing home care beds. The Medical Center has significant space, functional, and patient privacy deficiencies in the existing NHC unit.

There are currently 392 VA-owned and operated nursing home care beds in Medical District 8. There are currently 109 community nursing home beds being utilized by VA patients from this facility. Medical District Initiated Program Planning (MEDIPP) projects that, by 1995, the total need for VA nursing home care beds for this medical district will be 813. This project proposes to increase the number of nursing home care beds at this Medical Center from 58 to 120 beds.

The documentation of the number of VA beds needed required an assessment of the availability of community and state nursing home care beds for VA patients and the feasibility of converting or renovating existing VA space into nursing home care units. This determination is made through the MEDIPP process and considers state projections of growth in the nursing home care industry and state moratoriums on new construction, community nursing home occupancy rates, geographic dispersion of vacant beds, and whether community facilities meet VA fire and safety codes and VA criteria for community nursing home acceptance of VA patients.

The primary reason for this project is to provide the number of additional beds the Medical District plan determined as needed at this Medical Center. Additional resources will be required to meet the increased demand of nursing home care patients. Cost avoidance may occur due to more energy efficient construction, and other design and construction improvements, but is difficult to document and not obtainable.

IV. Background

There were three site alternatives developed for this project. They are:

Alternative 1: This alternative would provide a two-story 120-bed structure to the rear of Building 8.

Alternative 2: This alternative would provide a two-story 120-bed structure to the north of Building 37.

Alternative 3: This alternative would provide a two-story 120-bed structure to the southwest of Building 69.

Alternative 1 was rejected because the area to the rear of Building 8 would have been insufficient to provide for this nursing home care building.

Alternative 2 was selected because the surface area north of Building 37 would be large enough to accommodate the two-story prototype nursing home. The land area would provide for outside recreational zones and access for emergency vehicles.

Construction, Major Projects
VAMC Mountain Home, Tennessee
120-bed Nursing Home Care Unit

Alternative 3 was rejected because the site would have been difficult and costly to develop due to the presence of underground rock.

V. Correction of Code Deficiencies

The nursing home care building will be a totally new structure, designed and constructed to meet all current code requirements.

VI. Schedule

Complete preliminary plans	N/A
Complete construction	06/16/88

NOTE: As the nursing home care prototype is being used in the development of this project, there is no need for completed preliminary plans.

VII. Project Cost Summary

		Cost
New Construction 51,670 gross square feet @ $93.25		$4,818,000
Alterations		N/A
Subtotal (new construction and alterations)		$4,818,000
Other Costs:		
a. Sitework, utilities, demolition and surface parking	$951,000	
Total Other Costs	951,000	951,000
Total Estimated Base Construction Cost		$5,769,000
Construction Contingency (5 percent)	288,000	
SBA(8a) Allowance (8 percent)	462,000	
Contingency Reserve	750,000	750,000
Technical Services (7.5 percent)		489,000
Utilities Agreements		20,000
Total Estimated Base Cost		$7,028,000
Inflation Allowance		672,000
Total Estimated Project Cost		$7,700,000

VIII. Annual Operating, Staff and Equipment Cost

	Project Activation Costs		Present Facility Operating Costs	
Equipment cost		$700,000		N/A
One time non-recurring cost		528,000		N/A
Recurring costs:				
Additional manpower	FTE: 61	$1,769,000	FTE: 1218	$31,167,988
Other recurring		468,000		12,921,396
Total recurring		$2,237,000		$44,089,384

IX. Executive Order 12372 Compliance

The VA notified State and Areawide Clearinghouses on March 21, 1984. The State responded on April 30, 1984. No further comment has been received.

Construction, Major Projects
VAMC New York, New York
Outpatient and Clinical Addition and Alterations

I. Budget Authority

Total Estimated Cost	Available Thru 1986	1987 Request	1988 or Future
$94,300,000*	$17,700,000*	$76,600,000*	...

*These figures do not reflect the reductions imposed by Public Law 99-177.

II. Description of Project

This project proposes to consolidate the Satellite Outpatient Clinic, currently located at 252 Seventh Avenue, with Medical Center New York. The project is based on a space program of approximately 215,000 net square feet involving both construction of a new addition adjacent to the Medical Center and renovation in the existing facility. The addition will consist of a basement and four floors to be located between, and connected by, bridges to Building I. The addition will provide for vertical expansion of up to five floors.

Because of the limited size of the site, 56 parking spaces will be lost as a result of this project. The 1995 parking analysis shows a need for 270 parking spaces. Considering the existing spaces, this results in a deficit of 138 spaces.

Air conditioning is included in the project scope. A new switchgear building is planned to convert the electrical distribution system and will serve the addition and the existing facility. The scope of the project will include the following functions: outpatient care; audiology and speech pathology clinic; building management (linen service); electroencephalography clinic; eye and ear, nose, and throat clinics; laboratory; medical administration; alcohol dependence treatment clinic; day hospital; multiple sclerosis clinic; outpatient psychiatric; nuclear medicine; pharmacy; radiology, including magnetic resonance imaging; recreation (multipurpose room); surgical service including the operating room suite; surgical intensive care unit; surgical nursing units; supply processing and distribution; supply warehouse; and, hospital-based home care unit.

The drug dependence treatment clinic will not be relocated to the Medical Center from its current location at 252 Seventh Avenue. Space vacated on the nursing units as a result of this project will be backfilled by patient privacy projects and station-level projects; this will bring to approved space planning criteria the other services. These projects are proposed to be funded in future years, independent of this project. While no bed reduction will result from this project, the Medical District Initiated Program Planning (MEDIPP) projects that, by 1995, the bed level will be 767 including 13 dialysis beds. This represents a significant reduction from the current authorized bed level of 1,030 beds.

Draft and final environmental impact statements were published for public comment during 1981. The Administrator selected the build alternative by executing the Record of Decision on August 4, 1982.

III. Justification for Project

The Satellite Outpatient Clinic is in poor physical condition, has been cited for fire and safety deficiencies, and has limited access for the handicapped. The task force that evaluated the deficiencies at the Satellite Outpatient Clinic found that consolidation is desirable because it will improve quality and economy of patient care; eliminate duplication of equipment and staffing; minimize supervisory control problems; and better utilize the clinical affiliations.

The Medical Center was constructed in the early 1950's and virtually no new space has been added since that time. Radiology service, surgical service, nor supply processing and distribution meet the current criteria in terms of space or functional layout. Ambulatory care functions are fragmented throughout the Medical Center and are highly deficient in space. The Medical Center has serious circulation and vertical transportation problems. This project will alleviate the transportation problems and will result in an efficient functional alignment. Based on 1995 outpatient visit projections and taking the consolidation into account, the Medical Center will be required to accommodate more than double its current outpatient workload. The proposed project will bring the Medical Center into compliance for the critically deficient services, based on 1995 workload and staffing projections. The space provided for those functions included in the scope will meet VA space planning criteria and functional relationships will be significantly improved by this project.

This project is intended to correct and improve space and functional deficiencies. It will be designed to comply with and correct handicapped access, safety, electrical, code, and accreditation deficiencies. By consolidating the two clinics with the projected outpatient workload increase, the need for approximately 20 additional full time employees has been avoided.

Construction, Major Projects
VAMC New York, New York
Outpatient and Clinical Addition and Alterations

IV. Background

In order to provide flexibility, the project was designed in such a way that surgery, canteen, and/or renovation of the wards could be included or deleted from the scope without affecting the integrity of the remainder of the project. Following conceptual design, it was determined that canteen and ward renovation would be removed from the scope of this project and accomplished by the Medical Center through station-level projects.

The project was developed using the following current and 1995 projected workloads.

	Current	Projected
Beds	1,030	767
Outpatient visits	128,334	282,900*

*includes the consolidation of the two clinics with the projected outpatient workload increase.

V. Correction of Code Deficiencies

New construction and renovation within this project will be accomplished in accordance with the Joint Commission on Accreditation of Hospitals, National Fire Protection Association, and handicapped accessibility codes and requirements.

VI. Schedule

Complete preliminary plans	10/24/83
Complete construction	01/31/90

VII. Project Cost Summary

			Cost
New Construction	297,000 gross square feet @ $208.74		$61,996,000
Alterations	79,600 gross square feet @ $ 91.82		7,309,000
Subtotal (new construction and alterations)			$69,305,000
Other Costs:			
a. Sitework, utilities, demolition and surface parking		$2,441,000	
b. Switchgear		5,570,000	
c. 23rd Entrance		1,541,000	
Total Other Costs		9,552,000	9,552,000
Total Estimated Base Construction Cost			$78,857,000
Construction Contingency (5 percent)		3,943,000	
SBA(8a) Allowance		N/A	
Contingency Reserve		3,943,000	3,943,000
Technical Services (7.5 percent)			6,210,000
Impact Costs			317,000
Total Estimated Base Cost			$89,327,000
Inflation Allowance			4,973,000
Total Estimated Project Cost			$94,300,000

VIII. Annual Operating, Staff and Equipment Cost

	Project Activation Costs		Present Facility Operating Costs	
Equipment cost		$14,750,000		N/A
One time non-recurring cost		1,800,000		N/A
Recurring costs:				
Additional manpower	FTE: 99	$2,871,000	FTE: 2034	$57,826,400
Other recurring		1,800,000		25,365,506
Total recurring		$4,671,000		$83,191,906

IX. Executive Order 12372 Compliance

The VA notified State and Areawide Clearinghouses on June 24, 1983. No response has been received from either clearinghouse.

Construction, Major Projects
VAMC Palm Beach, Florida
New Medical Center

I. Budget Authority

Total Estimated Cost	Available Thru 1986	1987 Request	1988 or Future
$146,500,000	...	$ 5,000,000*	$141,500,000

*Funds being requested in 1987 are for site acquisition only.

II. Description of Project

This project proposes to construct a new medical center in the eastern section of Palm Beach County, Florida. The new medical center is programmed for 625 hospital beds and 240 nursing home care beds.

A site will be acquired using 1987 requested funds which will provide sufficient acreage for the main hospital, support buildings, and 1,240 parking spaces. An environmental impact statement is underway and is scheduled for completion and site selection by the Summer of 1986.

III. Justification for Project

Studies were conducted by the Veterans Administration to consider the health care delivery system in Florida. These studies documented the need for additional beds in Florida and led to the selection of Palm Beach County as a site for a new medical center.

In the Department of Medicine and Surgery's 1986-1990 Five-Year Medical Facility Construction Needs Assessment, Palm Beach appears on the list of medical centers currently judged most in need of construction, replacement, or major modernization.

IV. Background

Two studies were conducted by the Veterans Administration to consider the health care delivery system in Florida. The first study, "A Thirty Year Study of the Needs of Veterans in Florida," mandated by Public Law 97-101, documented the need for 1,251 additional Veterans Administration hospital beds in Florida to meet veteran population demand as projected to 1995. A second study, "A Report on Future Bed Need and Potential Sites for New VA Hospitals in Florida," completed in June 1983, analyzed hospital bed need in Florida by 1995, and detailed the Veterans Administration's criteria which led to the selection of the Palm Beach County site as the first of four new Florida locations for medical centers.

V. Correction of Code Deficiencies

New construction will be accomplished in accordance with all Joint Commission on Accreditation of Hospitals, National Fire Protection Association, and handicapped accessibility codes and requirements.

VI. Schedule

Complete preliminary plans	09/18/87
Complete construction	02/14/92

Construction, Major Projects
VAMC Palm Beach, Florida
New Medical Center

VII. Project Cost Summary

		Cost
New Construction 968,136 gross square feet @ $96.49		$ 93,418,000
Alterations		N/A
Subtotal (new construction and alterations)		$ 93,418,000
Other Costs:		
a. Sitework, utilities, demolition and surface parking	$7,821,000	
Total Other Costs	7,821,000	7,821,000
Total Estimated Base Construction Cost		$101,239,000
Construction Contingency (10 percent)	10,124,000	
SBA(8a) Allowance	N/A	
Contingency Reserve	10,124,000	10,124,000
Technical Services (10 percent)		11,136,000
Site Acquisition		5,000,000
Total Estimated Base Cost		$127,499,000
Inflation Allowance		19,001,000
Total Estimated Project Cost		$146,500,000

VIII. Annual Operating, Staff and Equipment Cost

	Project Activation Costs		Present Facility Operating Costs	
Equipment cost		$32,750,000		N/A
One time non-recurring cost		6,800,000		N/A
Recurring costs:				
Additional manpower	FTE: 1658	$48,082,000	FTE: 0	$ 0
Other recurring		20,607,000		0
Total recurring		$68,689,000		$ 0

IX. Executive Order 12372 Compliance

Notification of the State's single point of contact is pending the selection of the site for this project.

Construction, Major Projects
VAMC Pittsburgh (Aspinwall Division), Pennsylvania
Replacement Medical Center

I. Budget Authority

Total Estimated Cost	Available Thru 1986	1987 Request	1988 or Future
$53,200,000	...	$11,300,000*	$41,900,000

*Funds being requested in 1987 are for design and construction of a replacement boiler and chiller plant and design only for the replacement medical center.

II. Description of Project

This project proposes to construct two buildings, to be linked by a connecting corridor, which will replace the existing main hospital building, Building I. Building I presently houses 43 medical, 161 intermediate, and 228 nursing home care (NHC) beds. The first new building will accommodate 44 general medical beds, 160 intermediate care beds, and various support functions, such as dietetics, pharmacy, and rehabilitation medicine. The second building will provide space for 240 NHC beds. The total authorized bed capacity will increase from 432 to 444 beds.

The project also involves construction of a boiler, chiller, and switchgear building; renovation of Building 32 for administrative functions; and demolition of Buildings 1-6, 9, 17, 22, 27, 46, and 48 to permit the new construction and necessary sitework. The 1995 parking analysis shows a need for 224 parking spaces. Considering the existing spaces, this results in a deficit of 219 spaces. Since virtually all existing parking will be lost due to construction, the project's design includes 171 new spaces and proposes continued use of five existing spaces.

An environmental assessment was accomplished with a finding of no significant impact and was published in the Federal Register on March 20, 1985.

III. Justification for Project

Building I was built in 1924 with major additions completed in 1932 and 1938. Nursing units in this building have serious patient privacy deficiencies with more than four patients in many bedrooms and insufficient space in some bedrooms. Patient support systems on the units are also inadequate. Due to the lack of space, nursing units do not have separate clean and soiled utility areas and there is a shortage of storage space in the units. Of the 432 existing beds, rooms for only 24 beds are air conditioned. In addition, there is no central ventilation system in Building I. Life safety code violations include the design of the linen chutes in Building I, the lack of acceptable exits in the main dining room in Building 17, and the presence of dead end corridors in Building I. The elevators in Building I are in need of replacement.

Additional resources will be required to meet increased workloads and to provide for more sophisticated treatment modalities and maintenance of state-of-the-art equipment. Cost avoidance may occur because of more energy efficient design and construction, but it is difficult to document and not obtainable.

In the Department of Medicine and Surgery's 1986-1990 Five-Year Medical Facility Construction Needs Assessment, Pittsburgh (Aspinwall Division) appears on the list of medical centers currently judged most in need of construction, replacement, or major modernization.

IV. Background

There were four alternatives developed for this project. They are:

Alternative 1: This alternative would provide construction of a two-floor addition to the south end of Building I; demolition of the two southernmost wings of Building I; renovation of the remainder of Building I; construction of a one-floor addition to the west side of Building 1; demolition of Building 17; construction of a chiller building in place of Building 5; and renovation of Building 32.

Alternative 2: This alternative would provide construction of a three-floor addition on the east and south sides of Building I; demolition of three wings of Building I and renovation of the remainder of Building I; construction of a one-floor addition on the west side of Building I; demolition of Buildings 17, 6, 22, 27, and 5; construction of a chiller building south of Building 2; and renovation of Building 32.

Alternative 3: This alternative would provide construction of a building to replace the patient care facilities in Building I; construction of a boiler, chiller, and switchgear building east of Building 3; and demolition of Buildings 1-6, 9, 17, 22, 27, 46, and 48.

Construction, Major Projects
VAMC Pittsburgh (Aspinwall Division), Pennsylvania
Replacement Medical Center

Alternative 4: This alternative would provide construction of two buildings to replace the patient care facilities in Building 1; construction of a boiler, chiller, and switchgear building east of Building 3; and demolition of Buildings 1-6, 9, 17, 22, 27, 46, and 48.

All alternatives were developed using the following current and 1995 projected workloads.

	Current	Projected
Beds	204 (hospital) 228 (NHC)	204 (hospital) 240 (NHC)
Outpatient visits	3,365	5,500

Alternatives 1 and 2 were rejected because certain services remaining in Building 1 would have been bisected by major circulation corridors or public elevator lobbies. As a result, the functional design of these services would have been poor and patient control within these services difficult. Patient care on the nursing units remaining in Building 1 would have been hampered by the excessive distances that staff would be required to travel given the building's long, narrow wings. Constraints imposed by continued use of Building 1 would have produced inadequate functional relationships among services.

Alternative 3 was rejected because construction of a single building for nursing home care and other patients would have limited the development of an optimal nursing home care program. Construction of a single building would not have permitted use of the VA's nursing home care unit prototype design.

Alternative 4 was selected because the design of patient care facilities would not be constrained by the configuration of the existing Building 1. The design would include the VA's nursing home care unit prototype.

V. Correction of Code Deficiencies

New construction and renovation within this project will be accomplished in accordance with Joint Commission on Accreditation of Hospitals, National Fire Protection Association, and handicapped accessibility codes and requirements.

VI. Schedule

Complete preliminary plans	08/15/85
Complete construction	05/08/91

VII. Project Cost Summary

		Cost
New Construction 335,402 gross square feet @ $106.10		$35,588,000
Alterations 19,236 gross square feet @ $ 27.50		529,000
Subtotal (new construction and alterations)		$36,117,000
Other Costs:		
a. Sitework, utilities, demolition and surface parking	$5,615,000	
Total Other Costs	5,615,000	5,615,000
Total Estimated Base Construction Cost		$41,732,000
Construction Contingency (5 percent)	2,087,000	
SBA(8a) Allowance	N/A	
Contingency Reserve	2,087,000	2,087,000
Technical Services (7.5 percent)		3,286,000
Impact Costs		100,000
Utilities Agreements		200,000
Total Estimated Base Cost		$47,405,000
Inflation Allowance		5,795,000
Total Estimated Project Cost		$53,200,000

Construction, Major Projects
VAMC Pittsburgh (Aspinwall Division), Pennsylvania
Replacement Medical Center

VIII. Annual Operating, Staff and Equipment Cost

	Project Activation Costs		Present Facility Operating Costs	
Equipment cost		$8,240,000		N/A
One time non-recurring cost		1,064,000		N/A
Recurring costs:				
Additional manpower	FTE: 81	$2,349,000	FTE: 1549	$42,401,694
Other recurring		1,240,000		19,162,692
Total recurring		$3,589,000		$61,564,386

IX. Executive Order 12372 Compliance

The VA notified State and Areawide Clearinghouses on December 28, 1979. Southwestern Pennsylvania Regional Planning Commission was not interested in reviewing the project. The State Clearinghouse did not respond.

Construction, Major Projects
VAMC Salt Lake City, Utah
30-bed Spinal Cord Injury Center and Canteen

I. Budget Authority

Total Estimated Cost	Available Thru 1985	1986 Request	1987 or Future
$16,000,000	...	$16,000,000	...

II. Description of Project

This project proposes to construct an addition between Buildings 1 (main hospital) and 4 (intermediate care) for a 30-bed spinal cord injury (SCI) center, SCI research space, a new canteen, rehabilitation medicine service space, prosthetics and sensory aids space, and support space for lockers, lounges, toilets, and showers. Existing rehabilitation medicine space will be renovated. This project will also include a rehabilitation exercise course, one-story vertical expansion capability over the SCI nursing unit, three-story vertical expansion capability over the canteen, loading dock for the canteen, treatment of courtyard area (including fixed benches and tables, landscaping, fountains, areas for active exercise and barbecue facilities), and permanent relocation of Buildings 24 and 25 (trailers).

The 1995 parking analysis shows a need for 1,380 parking spaces. Considering the existing spaces, this results in a deficit of 343. Parking (58 spaces) and access (pedestrian and vehicular) for SCI and rehabilitation medicine areas are included in this project. Thirty parking spaces (21 handicapped, 2 van, and 7 regular) will be provided in connection with the SCI program. Twenty-eight spaces (16 additional spaces over what currently exists) will be provided for the credit union area. This parking is needed because of a change in traffic patterns caused by the new construction, the relocation of the canteen itself, and because of the loss of 47 parking spaces due to the new construction.

An environmental assessment was accomplished with a finding of no significant impact and was published in the Federal Register on March 14, 1984.

III. Justification for Project

The SCI beds to be provided at the Salt Lake City Medical Center will satisfy the demand for those services for the entire Medical District 23 as well as parts of Medical Districts 22 and 27. The integration of a research facility within the spinal cord injury center will serve as a major focus for research interests in this area and provide both immediate and long term benefits to the care and rehabilitation of the spinal cord injury patient. The present canteen service is hindered in its mission by location and size. It is currently some 30 percent undersized in comparsion to space planning criteria and located over 900 feet from the nearest patient room. In addition, all patients must travel to the canteen down a 500 foot corridor with a difficult slope. Most wheelchair patients require assistance to return to their wards and for that reason many do not attempt to visit the canteen. SCI rehabilitation medicine space is included as new construction and will disrupt the existing rehabilitation medicine space necessitating the need for renovation of that area. Vertical expansion capability is provided because the new building will occupy a central location on the Medical Center campus, thus allowing for possible future desirable functional adjacencies. Comparable land is not readily available.

The primary reason for this project is to provide the number of spinal cord injury beds the Medical District plan determined as needed at this Medical Center. Additional resources will be required to meet increased demand of spinal cord injury patients. Cost avoidance may occur due to more energy efficient construction, and other design and construction improvements, but is difficult to document and not obtainable.

IV. Background

The Medical Center had developed a detailed facility master plan which served as a basis for the SCI center site selection. After studying their recommended site and other possible locations, it was determined that their initial site selection was the only feasible alternative. The proposed SCI center will be located between Buildings 1 and 4. This is consistent with the Medical Center's goal of consolidating patient care areas in and around Buildings 1 and 4.

V. Correction of Code Deficiencies

The spinal cord injury building will be a totally new structure, designed and constructed to meet all current code requirements.

VI. Schedule

Complete preliminary plans	11/29/84
Complete construction	12/02/88

Construction, Major Projects
VAMC Salt Lake City, Utah
30-bed Spinal Cord Injury Center and Canteen

VII. Project Cost Summary

		Cost
New Construction 107,317 gross square feet @ $102.85		$11,038,000
Alterations 7,347 gross square feet @ $ 65.33		480,000
Subtotal (new construction and alterations)		$11,518,000
Other Costs:		
a. Sitework, utilities, demolition and surface parking	$ 892,000	
b. Tunnel to Building 2	102,000	
c. Connecting corridor to Building 4	100,000	
d. Trailer relocation	113,000	
Total Other Costs	1,207,000	1,207,000
Total Estimated Base Construction Cost		$12,725,000
Construction Contingency (5 percent)	636,000	
SBA(8a) Allowance	N/A	
Contingency Reserve	636,000	636,000
Technical Services (7.5 percent)		1,002,000
Impact Costs		167,000
Utilities Agreements		20,000
Total Estimated Base Cost		$14,550,000
Inflation Allowance		1,450,000
Total Estimated Project Cost		$16,000,000

VIII. Annual Operating, Staff and Equipment Cost

	Project Activation Costs		Present Facility Operating Costs	
Equipment cost		$1,150,000		N/A
One time non-recurring cost		440,000		N/A
Recurring costs:				
Additional manpower	FTE: 133	$3,857,000	FTE: 1133	$31,864,160
Other recurring		600,000		14,987,965
Total recurring		$4,457,000		$46,852,125

IX. Executive Order 12372 Compliance

The VA notified State and Areawide Clearinghouses on April 21, 1983. No response has been received to date.

Construction, Major Projects
VAMC Tampa, Florida
120-bed Nursing Home Care Unit

I. Budget Authority

Total Estimated Cost	Available Thru 1986	1987 Request	1988 or Future
$7,100,000	...	$7,100,000	...

II. Description of Project

This project proposes to construct a two-story vertical addition to the original 120-bed nursing home care (NHC) unit. The new construction will be compatible with that of the existing NHC unit. All required electrical and mechanical systems will be included in order to provide a completely operational nursing home care facility.

The 1995 parking analysis projects a need for 2,084 parking spaces. Considering the existing spaces, this results in a deficit of 1,201 spaces. Approximately 60 of these spaces are needed to support the new NHC unit addition. A parking garage to accommodate the deficit spaces is being planned for the Medical Center as a part of the future project to provide clinical and spinal cord injury additions.

An environmental assessment was accomplished with a finding of no significant impact and was published in the Federal Register on March 29, 1984.

III. Justification for Project

There are currently 720 VA-owned and operated nursing home care beds in Medical District 12. There are currently 162 community nursing home beds being utilized by VA patients from this facility. Medical District Initiated Program Planning (MEDIPP) projects that, by 1995, the total need for VA nursing home care beds for this medical district will be 2,040. This project proposes to increase the number of nursing home care beds at this Medical Center from 120 to 240 beds.

The documentation of the number of VA beds needed required an assessment of the availability of community and state nursing home beds for VA patients and the feasibility of converting or renovating existing VA space into nursing home care units. This determination is made through the MEDIPP process and considers state projections of growth in the nursing home industry and state moratoriums on new construction, community nursing home occupancy rates, geographic dispersion of vacant beds, and whether community facilities meet VA fire and safety codes and VA criteria for community nursing home acceptance of VA patients.

Several studies undertaken by the VA have indicated the need for expanded veteran institutional care facilities due to veterans 65 years and older comprising the fastest growing segment of the population. The veteran population moving to Florida is estimated to be over 5,000 per month. There are currently 1,400,000 veterans being served in Florida. This is expected to almost double to 2,500,000 million by the year 2000. The primary service area for Tampa currently serves 30 percent of these veterans.

The primary reason for this project is to provide the number of additional beds the Medical District plan determined as needed at this Medical Center. Additional resources will be required to meet the increased demand of nursing home care patients. Cost avoidance may occur due to more energy efficient construction, and other design and construction improvements, but is difficult to document and not obtainable.

IV. Background

The existing 120-bed NHC unit was designed for future expansion for nursing home care beds. Consequently no alternatives other than to construct a two-story addition to the existing 120-bed NHC building were considered.

V. Correction of Code Deficiencies

The addition to the nursing home care building will be totally new construction, designed and constructed to meet all current code requirements.

VI. Schedule

Complete preliminary plans	04/28/86
Complete construction	05/18/89

Construction, Major Projects
VAMC Tampa, Florida
120-bed Nursing Home Care Unit

VII. Project Cost Summary

		Cost
New Construction 47,762 gross square feet @ $ 89.00		$4,251,000
Alterations 5,248 gross square feet @ $135.00		708,000
Subtotal (new construction and alterations)		$4,959,000
Other Costs:		
a. Sitework, utilities, demolition and surface parking	$163,000	
Total Other Costs	163,000	163,000
Total Estimated Base Construction Cost		$5,122,000
Construction Contingency (5.3 percent)	271,000	
SBA(8a) Allowance (8 percent)	410,000	
Contingency Reserve	681,000	681,000
Technical Services (7.5 percent)		435,000
Utilities Agreements		300,000
Total Estimated Base Cost		$6,538,000
Inflation Allowance		562,000
Total Estimated Project Cost		$7,100,000

VIII. Annual Operating, Staff and Equipment Cost

	Project Activation Costs		Present Facility Operating Costs	
Equipment cost		$800,000		N/A
One time non-recurring cost		690,000		N/A
Recurring costs:				
Additional manpower	FTE: 117	$3,393,000	FTE: 1918	$53,382,734
Other recurring		900,000		22,326,854
Total recurring		$4,293,000		$73,709,588

IX. Executive Order 12372 Compliance

The VA notified State and Areawide Clearinghouses on January 19, 1983. No response has been received from either clearinghouse.

UNITED STATES GENERAL ACCOUNTING OFFICE
Washington, D.C. 20548

FOR RELEASE ON DELIVERY
EXPECTED AT 2 P.M.
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TESTIMONY OF

JOHN R. CHERBINI

SENIOR ASSOCIATE DIRECTOR

ACCOUNTING AND FINANCIAL MANAGEMENT DIVISION

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

ON

MEDICAL CARE PLANNING AND CONSTRUCTION PLANNING IN THE VETERANS ADMINISTRATION

Mr. Chairman and Members of the Committee,

I am pleased to be here today at the request of the Committee to share with you our views on:

- --VA's medical care and construction planning processes;
- --Booz, Allen & Hamilton/RTKL's recent study of VA's construction processes;
- --VA's proposed merger of the Department of Medicine & Surgery and the Office of Construction; and
- --VA's sizing of surgical suites in new and replacement hospitals.

At the request of this Committee, we recently completed a review of VA's major financial management processes, focusing on medical care and major construction. Our report addresses both the strengths and weaknesses of those processes, and the data on which they rely. The report is now with VA for agency comments. With the exception of my comments on surgical suites, my statement primarily reflects the results of that review.

Our review was conducted using a model that views financial management as four distinct, but interrelated phases linked by reliable, useful information. Those phases are: planning/programming; budget formulation/justification; budget execution; and audit/evaluation. Accurate, timely, and useful information is the very foundation of any effective management process, and weaknesses in that information can adversely affect management decisionmaking.

OUR FINANCIAL MANAGEMENT PROFILE REPORT

Earlier, we provided the Committee with copies of our financial management profile of VA, which contained an inventory of VA's financial management systems and identified a number of weaknesses that affected the accuracy and reliability of the information produced by those systems.[1] A major finding of that study was that many of VA's systems are antiquated, slow, and often unable to produce accurate, useful information when needed for decisionmaking, cost-control, and effective program management. Many of these findings have been confirmed by VA's own annual reports produced in compliance with the Federal

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[1] Veterans Administration: Financial Management Profile (AFMD-85-34, September 20, 1985).

Manager's Financial Integrity Act of 1982. Additional problems, and VA's plans to correct them, are also discussed in VA's 5-year Automated Data Processing Plans.

SOME MAJOR ISSUES IN MEDICAL CARE AND CONSTRUCTION PLANNING

I would now like to discuss some of the major issues we found in VA medical care and construction planning as part of our review of VA's major financial management processes. As the members of this Committee well know, VA faces an enormous challenge in planning to meet the medical care needs of veterans in the next two decades--especially the needs of veterans 65 and older, whose number is expected to triple between the years 1980 and 2000. To meet that challenge, VA needs two basic things: (1) decision processes that managers can use to systematically identify cost-effective ways of meeting specific and realistic medical care and construction planning objectives and (2) reliable, useful information to support those processes. In both areas, VA's medical care and construction planning could be improved. VA is aware of many of the issues discussed in this testimony and has efforts underway to address some of them.

In our view, VA medical care and construction planning should address the following issues:

--How many veterans in which eligibility categories are now receiving VA medical care and where?

--For what illnesses are they being treated, using what resources, and at what cost?

--What changes does VA expect in veteran demand for care by eligibility category and geographic location?

--What changes does VA expect in the types of illnesses for which veterans seek care (for example, is an increase in the demand for care from veterans 65 and older likely to result in an increased demand for long-term care)?

--What clinical resources and facilities will be needed to provide that care at least cost and where?

MAJOR FINDINGS OF OUR REVIEW

We found that VA does not fully address some of these questions in either medical care or construction planning. VA also lacks the reliable per patient clinical and cost data essential for assessing the current use of medical care resources and evaluating future needs.

Improvements Needed in the Medical Care Planning Process

VA assesses the future medical care needs of veterans through its Medical District Initiated Program Planning process, called MEDIPP. To assess which veterans are now using VA health care, and to project future demand for care, MEDIPP uses age groups, not categories of eligibility for care. A major reason is that the goal of MEDIPP, at least through the 1984 MEDIPP cycle, has been to provide medical care to ALL eligible veterans requesting care.

Age groups are certainly one useful way of assessing future demand. As veterans age, the types of care they need are likely to change. Veterans over 75, for example, are the most likely to need nursing home care.

However, one reason for using eligibility categories in MEDIPP is that law and regulations provide that access to VA health care be on a priority basis, as determined by a veteran's eligibility for care. Veterans with service-connected disabilities have first claim to VA health care when budgets do not permit serving all eligible veterans requesting care. By its own estimates, VA does not now have the resources to serve all eligible veterans seeking care, and if current budgetary trends continue, VA is not likely to be able to do so any time soon. Thus, VA's medical care planning goal of serving all eligible veterans requesting care may be unrealistic in the current budgetary environment. If VA assessed future medical care needs by eligibility category, it could identify those veterans least likely to be served within specific budgetary limits.

To improve MEDIPP, VA introduced a number of changes into the process for the preparation of the November 1985 and subsequent MEDIPP plans. (The 1985 MEDIPP plans will be used in developing the fiscal year 1988 budget.) One of those changes is the introduction of annual operating plans in which medical planners identify priorities using three different budgetary assumptions--no changes in the 1986 operating budgets of all medical facilities in the district, a 5 percent budgetary increase, and a 5 percent decrease. This change may provide VA a basis for establishing more realistic goals, clearer priorities, and a better link between MEDIPP and the budget. In the past, MEDIPP planners have not been required to consider budgetary limits in setting priorities.

VA does not systematically try to estimate the types of illnesses (i.e., the "casemix") for which veterans may be expected to seek care in the future. While the Department of Medicine and Surgery (DM&S) has provided medical districts a casemix projection model for inpatient care, districts are not required to use it in developing their MEDIPP plans. Yet, the types of illnesses for which veterans seek care, not just their numbers, determine the clinical resources and facilities needed to provide care and, thus, the costs to provide the care.

According to recent testimony by the Chief Medical Director, one objective of MEDIPP is to provide within each medical district the full range of medical services that VA expects veterans within that district to need. However, VA has no consistent basis for identifying what medical services should be provided at each facility in a district because VA has not yet defined the basic range of medical services that should be available at its primary, secondary, and tertiary care hospitals.[2] Such definitions are useful in construction planning and design as well as medical care planning.

Data Improvements Needed in MEDIPP

Even if VA revised its MEDIPP process to do the kinds of analyses just discussed, its efforts would be hampered by inaccuracies in available clinical and cost data.

The Importance of Per Patient Clinical and Cost Data

Perhaps most importantly, VA does not currently have reliable per patient clinical workload and cost data. Such data are the foundation of not only effective health care planning, but efficient hospital management as well. This is because, as previously noted, the illnesses for which patients are treated, not just their numbers, determine the clinical resources and facilities needed to treat them and, thus, the cost of that treatment. Without this per patient data, it is difficult to assess the most cost-effective ways of providing quality care for any specific mix of illnesses.

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[2] In general, these can be thought of as a continuum. Primary care hospitals provide relatively simple medical services, while tertiary care hospitals are capable of treating the most complex cases.

The importance of per patient clinical and cost data has been highlighted by VA's implementation of its Casemix-based Resource Allocation Methodology for allocating a growing portion of each hospital's operating budget. Under this system, hospitals are essentially reimbursed a specific amount for each type of illness they treat. If a hospital's costs exceed VA's national average, it will lose funds. But VA's current workload and accounting systems do not provide reliable information on the actual costs of treating any specific patient or illness. Therefore, hospital managers and medical care planners find it difficult to identify ways of reducing those costs by reducing, where appropriate, the resources used to treat those illnesses.

Clinical and Cost Data Used in Medical Care Planning Are Inaccurate

The current clinical and cost data used by VA in health care planning are not always accurate, but VA is working to improve them.

Clinical Data: VA recent hired SysteMetrics to conduct a study of its primary inpatient data base, the Patient Treatment File (PTF). Using 1984 data, that study found an error rate of about 35 per cent in the major diagnoses (the diagnosis responsible for the major portion of a patient's length of stay in the hospital) recorded for hospitalized patients. The major diagnoses recorded in the PTF are used to assign patients to Diagnosis Related Groups, or DRGs. DRGs are the basis for measuring each hospital's inpatient workload in VA' Casemix Allocation Methodology, which is used to allocate a growing portion of each hospital's operating budget. Consequently, hospitals are trying to lower the number of errors in the PTF, especially those that may understate their actual workload as measured by DRGs.

There are errors as well in the outpatient work load reported in VA's Automated Management Information System (AMIS). Out-patient visits, for example, are understated in AMIS. One reason for this is that outpatient clinic visits by certain categories of inpatients, such as nursing home patients, are not recorded in AMIS. Errors in both the PTF and AMIS affect health care planning because the data in these systems are used to assess current workload at each facility and project future demand for health care.

Cost Data: MEDIPP estimates program costs using the quarterly RCS-10-141 cost reports. These reports reflect quarterly program cost estimates, not actual program costs captured in VA's accounting systems.

The costs reported in the RCS-10-141 reports are also the costs used in VA's Casemix Resource Allocation Methodology to measure hospital efficiency. The same costs are also used to develop a portion of VA's medical care budget. In its guidance to hospitals on the implementation of the Casemix Methodology, VA cautions that the process of allocating program costs for the RCS-10-141 reports is "highly sensitive to error." Because of their use in the Casemix Methodology, hospitals have an incentive to improve the accuracy of the costs reported in the RCS-10-141.

However, VA recognizes that there are limits to its ability to improve the cost estimates in the RCS-10-141 reports and to the usefulness of these reports as a means of controlling costs. Therefore, VA is working to develop a system for capturing the essential per patient workload and cost data it needs for effective health care planning and hospital management.

CONSTRUCTION PLANNING

At the time we began our review, VA had hired Booz, Allen & Hamilton/RTKL Associates to conduct a comprehensive study of VA's construction processes. We understand that VA largely agrees with the major findings and conclusions of the report, but not necessarily with its recommendations. We reviewed the methodology and workpapers used in that study, and we concur with its major findings and conclusions.

Issues in the Construction Planning Process

The Booz, Allen & Hamilton study identified three principal issues in VA construction planning:

--VA's health care planning and construction planning have not been effectively integrated. One key reason, the study concluded, was that MEDIPP did not produce a national health care strategy with a set of clear medical care priorities to guide construction planning and priority setting. We have already noted some of the reasons why that is so.

--No clear, national construction strategy or generally reliable and up-to-date supporting data exist to guide construction planning, priority setting, design, and construction. Booz, Allen & Hamilton concluded that this was largely because construction planning tends to focus on individual projects rather than on developing a national construction strategy. This approach does not provide an adequate foundation for carrying out effective long-term planning. The result is inefficient use of resources, poorly coordinated construction activities at individual facilities, and ineffective project planning.

--There was no clear point of accountability for the results of the construction process, including planning, below the VA administrator.

Construction Planning and Priority Setting Data Need to be Improved

Both our review and the Booz, Allen & Hamilton study identified potential improvements in the data used in VA's construction planning and priority setting process. For example:

--Our review identified two types of data whose absence has affected VA's ability to develop medical care priorities in MEDIPP or develop a national construction strategy. VA has not had either comprehensive, current clinical inventories for each of its medical care facilities, or a comprehensive, current assessment of the physical condition of each. VA has efforts underway to develop both. Each is important because VA chooses construction projects on the basis of both the medical care needs the project will serve, and such physical considerations as the fire and safety conditions in its hospitals.

--One finding of the Booz, Allen & Hamilton study affects not only construction planning, but medical care planning as well: Due in part to a lack of definition within the Department of Medicine and Surgery, VA does not have facility planning standards that reflect current medical operating modalities (i.e., treatment patterns). VA's ability to update facility planning standards, if it had them, is limited by its lack of reliable clinical workload data for specific illnesses. Such data are also needed to develop functional workload and design standards for such hospital functions as laboratory, radiology, and pharmacy. When fully operational, the clinical data from the Decentralized Hospital Computer Program, now being installed in 169 VA hospitals, should provide much of the data needed to develop both treatment modalities and functional workload and design standards.

All these factors affect VA's new prioritization methodology, completed after Booz, Allen & Hamilton had issued its final report. Using a series of weighted factors based on the medical care needs projects will serve and the physical condition of existing facilities, the new methodology ranks construction projects. This is clearly a step in the right direction. But, the methodology must rely on currently available data, which is not always reliable.

The Proposed Merger

We believe that the Booz, Allen & Hamilton study highlights some important issues in VA construction planning, design, and construction that VA should address in a systematic and comprehensive fashion. VA is proposing the merger of the Office of Construction and the Department of Medicine and Surgery under the authority of the Chief Medical Director. This merger would provide a point of accountability below the Administrator, as recommended in the Booz, Allen & Hamilton report. But the merger will fall short of producing fundamental improvements, unless it is accompanied by a phased comprehensive strategy for improving VA's construction processes and the data on which they rely. VA's proposal does not indicate if or how VA proposes to develop that strategy.

SIZING OF VA SURGICAL SUITES

Our recent work on the sizing of VA surgical suites provides another example of how VA could improve its construction planning by developing criteria based on actual and projected workload at a facility. In March 1981, we reported that VA's criteria for determining the number of operating rooms it needed in new or replacement hospitals was resulting in the construction of too many rooms.[3] We recommended that VA use a model (such as the one we presented in our report)[4] that focused on the unique surgical workload of each medical center instead of building 1 operating room for every 28 surgical beds planned for the hospital. VA agreed with the principle, but not the model we had developed.

Last year, we began a separate review of how VA has been determining its operating room requirements since our 1981 report was issued and, in view of the absence of any revised criteria since 1981, whether the number of operating rooms planned or under construction was consistent with that derived using our 1981 model. We found that VA was still using the same criteria it used in 1981 (1 operating room for every 28 surgical beds) to determine its operating room needs. Applying our model to 24 construction projects planned since October 1982, we determined that VA is planning to build 29 unnecessary operating rooms, at a cost of $5.8 million.

In May 1983 VA began developing its own model (which we understand is now completed and under review in the Department of

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[3] Better Guidelines Could Reduce VA's Planned Construction of Costly Operating Rooms (HRD-81-54, March 3, 1981).

[4] Ibid.

Medicine & Surgery). We have two concerns about VA's new model. First, it does not use a preset use rate to determine how much operating rooms will be used. We recommended in 1981, and continue to believe, that VA should use an 80 percent use rate. Second, the proposed model would allow VA planners to adjust workload projections to reflect possible changes in several planning factors, such as Medicare policies or the facility's mission, but it does not call for central guidance or monitoring of those adjustments.

We have drafted our report on this review and have received comments from officials in VA's facility planning and construction offices as well as officials who developed VA's new model. We expect to issue the report shortly.

That concludes my statement, Mr. Chairman. We would be happy to answer any questions you or other members of the Committee may have.

**THE MARYLAND
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TESTIMONY

Proposed Veterans Administration Hospital
before
Senate Committee on Veterans' Affairs

April 10, 1986

Chairman Murkowski, members of the Committee. My name is Winfield M. Kelly. I am a Prince George's County businessman, former elected official, and a hospital trustee. I'm here today as a Director and representative of the Maryland Chamber of Commerce and, with the individuals here today, part of a coalition of organizations in our state who believe that superb medical care for Maryland veterans can be delivered without construction of the proposed $110 million Veterans Administration replacement hospital in downtown Baltimore.

(Introduce Others)

Although as civic and business leaders we appreciate all of the advantages of a major federal construction project in our state, we are convinced that in an era in which federal spending must be curtailed, new and innovative ways must be found to meet our commitment to America's veterans.

And let me be clear. First-rate care for veterans must be our number one priority. We are well aware, too, that the Veterans Administration is faced with a growing demand for long-term care and continuing responsibilities in psychiatric and rehabilitative care.

If good health services for our deserving veterans genuinely is the federal government's goal, doesn't it make sense to use all of the best resources available to their fullest extent? Maryland has 54 community acute care hospitals, 26 of them in the Baltimore area. We have perhaps the nation's most sophisticated system of regional trauma centers and teaching facilities. Our state's hospitals include the University of Maryland Medical System with which the new Baltimore VA facility would be affiliated.

Maryland hospitals, like community institutions in every state, have witnessed dramatic changes over the past several years. For a variety of reasons, inpatient hospital utilization is falling. More care is being provided on an outpatient basis, resulting in fewer admissions. Payment policies and new technology have combined to cause the average length of a patient's stay to decrease. In short, new capacity is available in community institutions where it did not exist before. The post World War II era pressure to build both community and VA acute care facilities to serve a growing population has disappeared.

The coalition of business, labor, health care providers, and state health regulators before you today believes the time and conditions are right to try a new pro-veteran alternative to the construction of an expensive new VA hospital in Baltimore—a building that is, today, years away from admitting its first patient. The new facility simply is not needed.

When excellent facilities stand ready to serve and when we must keep a close rein on our resources, we owe it to our veterans to ensure for them the best care—wherever it is available and as soon as possible.

We would urge your Committee, the Congress, and the Administration to give serious consideration to an experiment in Maryland. We would support the creation of a Veteran's Key Card program for a trial period of three to five years. During that time, any Maryland veteran eligible for and needing health care could get that care at the hospital of his or her choice. Rather than journey to Baltimore or into Washington, the Maryland veteran on the Eastern Shore or Western Maryland could receive care in his or her own community. In the Baltimore area, University Hospital, with which a new VA facility would be affiliated, ought to be the focus of the experiment. As of the end of 1985, University was operating at about 62% of its licensed 785-bed capacity. That means that approximately 300 beds would have been available to care for veterans.

Maryland hospitals are tightly regulated by our Health Services Cost Review Commission. Thus for the period of the experiment the costs of treating patients could be closely monitored and regulated. It is also noteworthy that the cost of an average stay in a Maryland hospital is slightly below the national average. Moreover, we have a sophisticated system in place to oversee and ensure quality of care.

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During the experiment, the VA could move forward with its plan to upgrade and refocus the missions of its three other Baltimore area facilities. If, at the experiment's conclusion, the need for a new acute care hospital is demonstrable, it is likely the nation will be better able to afford the cost if the crushing deficit is under firm control.

Meanwhile, an important public policy question would have been addressed. And it is our sincere belief that such an experiment would prove successful and thus become an important and valuable new part of the VA health system.

What we are suggesting is not new. It has been proposed before in other forms. Organizations in Maryland have been backing such a test since the late 1970's. But is has been hard to assemble support for reasons I am sure do not need to be explained to you.

But times are different. The American health care system is undergoing dramatic change. The federal government is under unprecedented fiscal pressure. New challenges confront the Veterans' Administration. There is an opportunity to ensure that our veterans have access to the best care available, regardless of the future, by employing resources already on line and delivering care.

As a matter of fact, in the Palm Beach area of Florida, a similar controversy is at hand over the construction of a new VA hospital there. Congressman Dan Mica and his colleague, Congressman Tom Lewis, are supporting an experiment there by way of contracting with community hospitals for some veterans care. It is most worthy of a try.

We urge you to encourage the experiment we propose in Maryland. It offers the potential for everyone to come up a winner--veterans, the community, the University of Maryland Medical System, the federal government, and taxpayers.

Thank you. I or my colleagues with me would be pleased to discuss any questions you may have.

Statement of

The American Legion

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by

PAUL S. EGAN, DEPUTY DIRECTOR
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THE AMERICAN LEGION

and

RODNEY S. KIRK, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE

ASSORTED VA HEALTH CARE ISSUES

April 10, 1986

Mr. Chairman and Members of the Committee:

The American Legion appreciates this opportunity to present its views on the several issues under consideration today that relate to various aspects of Veterans Administration medical facility construction.

The first issue that we shall address is the Administration's construction authorization request for FY 1987. As the Committee is well aware, the Administration's proposal is $415.5 million, which reflects a reduction of $331.9 million from the current fiscal year.

As we have stated for the past several years, it is just not wise to drastically reduce the funding for medical construction when the capital plant of the VA health care system is deteriorating. It seems that the Office of Management and Budget has it in mind to allow the system to continue to deteriorate through underfunding of the renovation and replacement program, which is one of the primary reasons for the current state of degeneration. What happens then? Is it OMB's intention to reduce the system until there is none?

The American Legion believes very strongly that it is important to maintain the capital plant of the VA medical care system, and that adequate funding must be provided to upgrade and replace existing facilities.

The projects that are included in the Administration's major construction proposal are a replacement medical center in Baltimore; a replacement medical center in Augusta, GA; bed replacement and modernization at the Dayton, Ohio VAMC; fire and safety improvements at Wood, WI; environmental improvements, patient and nursing home care buildings at North Chicago; outpatient, clinical and nursing unit addition, Salem, VA; geropsychiatric building, Salisbury, NC; electrical distribution, Salt Lake City; renovate buildings 10 and 90, Waco, TX; and a research and education building, White River Junction, VT.

We must say that we are extremely pleased that the Administration has finally come around to the point of view that has been espoused by The American Legion since the mid 1970's with respect to the need for a replacement hospital in Baltimore.

We are greatly concerned about the Administration's "plan for the future" that dictates no new independent nursing home care unit construction, and greater reliance on community nursing homes. The nursing care formula currently in use consists of 40 percent VA, 40 percent State Homes and 20 percent private sector nursing homes. The new plan calls for 30 percent VA, 40 percent State Homes, and 30 percent private sector facilities.

This proposal of a new long-term care policy that emphasizes the use of community nursing homes is not really a new concept. The American Legion has opposed this idea in the past for several very good reasons. We do not disagree that community nursing homes play an important role in VA's effort to provide nursing care to veterans. However, there are certain postulates that must be taken into consideration.

It has been stated by some that the costs of constructing and operating VA nursing home care units are higher than those in the private sector. It must be realized that these government owned and operated facilities have vigorous obligations placed upon them to provide optimum quality medical care to veteran patients. Ongoing oversight is provided by the Congress, The American Legion and other veterans organizations, and by the VA itself through its Professional Services. Community nursing homes are not subjected to such thorough and constant policing. In addition, the VA nursing home patient load has a high percentage of veterans who because of the care they require are frequently not acceptable to community nursing homes. Veterans in VA nursing home care units are usually sicker and stay longer than individuals in private sector nursing homes and, therefore, they require more specialized facilities and equipment for their care. The community nursing homes are commercial ventures and many times refuse such cases because they are not profitable.

An additional factor that must be considered is the lack of availability of community nursing home beds in some areas. There exists across the country an unequal distribution of long-term care resources. The availability of nursing home beds in some instances even varies in different parts of a State. An example of existing need is Providence, Rhode Island, where we have supported the construction of a 60-bed nursing home for several years. This is but one example of why we are thoroughly convinced that it is not a good idea for the Veterans Administration to cease construction of nursing home care units.

As for the replacement and renovation projects scheduled for FY 1987, based on the reports of our Field Representatives who make site visits to all of these facilities, we can assure the Committee all of the work scheduled is needed, and much of it is long overdue.

However, it is distressing to see that only two replacement hospitals are included in this projection. The Office of Management and Budget is only fooling itself by delaying the funding for badly needed projects. This is false economy, pure and simple and will end up costing more in the long run, rather than saving the Government money, because the longer the projects are delayed the more it will cost to build them. And in the meantime the capital plant continues to decay.

Allowing this system to deteriorate makes no sense at all and, in fact, contradicts the Administration's position on national defense when one considers that VA medical centers constitute the principal contingency resource to treat returning casualties during a national wartime emergency.

It is obvious to The American Legion that Congressional intervention is the only possible solution to this abominable situation, and fortunately this Committee has initiated a move in that direction through its recommendations to the Budget Committee that additional funding be added to the FY 1987 VA Budget for medical construction.

Mr. Chairman, we will now address our comments to the proposed reorganization within the Veterans Administration that will consolidate the Office of Construction with the Department of Medicine and Surgery.

The American Legion is extremely supportive of the VA Medical Construction Program, especially the renovation and replacement of medical care facilities in the system that are in varying stages of deterioration and disrepair. We have set forth our reasoning for this support earlier in this statement, and on many other occasions before this Committee.

We have also previously expressed our concerns about cost overruns on major construction projects brought about by occurrences such as frequent modifications to architect/engineering and construction contracts; and design slippage also caused by changes in original contracts. It has been stated that the Legion believes the VA needs to be more precise in its planning of construction projects, as it would appear to us that excessive and expensive changes have been caused by improper planning.

On October 31, 1985, former Administrator Harry Walters announced that as a result of among other things, the report on the study that was conducted by Booze, Allen and Hamilton and RTKL Associates, and discussions with principals of these companies; and after seeking the advice and opinions of veterans service organizations and Congressional staff, that he intended to effect the transfer of the Office of Construction. He stated that these discussions confirmed that a major organizational realignment is a prerequisite to an improved VA construction program.

During the preliminary discussions with Mr. Walters, representatives of The American Legion stated that this organization would certainly support the proposed transfer if it would enhance the construction process through the development of a closer relationship between these two important VA functions. We continue to hold that position. It is felt that the transfer will enhance productivity and result in considerable savings through further reduction of the spending of precious dollars on unnecessary or frivolous modifications to construction projects.

With the transfer of O/C to DM&S, the Chief Medical Director will have full responsibility and accountability for the Agency's construction program. The Administrator will retain independent oversight of the construction program. The Controller and General Counsel office will continue to monitor and review construction related appropriations, contracts, regulations, and directives. The establishment of a new position of Associate Deputy Administrator for Management will provide independent oversight of construction analysis. We also understand that a Construction Analysis unit will be part of a new office of Program Analysis and Evaluation to be created by the transfer of the Office of Program Planning and Evaluation to the Office of the Associate Deputy Administrator for Management.

It would appear to us that the reorganization will add accountability to the Construction Program and eliminate a great deal of inefficiency that has developed as a result of the bureaucratic entanglement in which major construction projects have become enmeshed under the current organizational structure. A major problem that has been identified is a breakdown in communications between local VA officials and program officers in Washington.

Local input is necessary and helpful in the successful completion of a project. A case in point is the situation that occurred in Salt Lake City. In that particular case, VA employees assigned to the medical center noted many deficiencies within the new addition, but their concerns were not addressed by officials in Washington, apparently because of a lack of resources and the fear that implementing changes would further delay the entire project. As this Committee well knows, these concerns were later addressed, at a much higher cost to the taxpayer than if the requests by local officials for corrective action were honored when they were first voiced.

The situation at Salt Lake City highlighted the lack of accountability, local input, and communication that is inherent within the current program. An American Legion Special Survey in March 1984 of the Salt Lake City VAMC situation resulted in ten recommendations being submitted to Department of Medicine and Surgery officials. The majority of these recommendations focused on the need to strengthen the review process which is accomplished in Central Office; the need to have the Resident Engineer work for, and answer to, the VAMC Director; the blatant lack of communication; and the absolute need for obtaining local input throughout the life of the project. The situation at Salt Lake City is but one example of the problems that have developed over the years.

To conclude our comments on this issue Mr. Chairman, The American Legion is supportive of the planned reorganization that will transfer the Office of Construction to the Department of Medicine and Surgery. The extensive study by Booze, Allen and

Hamilton/RTKL Associates clearly illustrates that the separation of responsibilities for the Veterans Administration's planning, design and construction program between these two components has created an extreme amount of confusion over roles and responsibilities in the construction process. The study report further identifies a distinct lack of accountability in the construction program.

The plan to streamline the construction process should result in improved lines of communication, increased cooperation among program officials at all levels, and substantial cost savings in the development and completion of VA medical construction projects.

You may be assured that The American Legion will continue to closely monitor ongoing renovation and replacement projects, and other construction, both major and minor, through surveys by our Field Representatives. As is our present practice, we will continue to provide copies of our site visit reports to this Committee which contain information on the progress of ongoing construction, as well as construction needs that are identified at specific VA medical care facilities.

The third issue to which we shall speak relates to consideration of purchasing or leasing existing private sector medical facilities by the Veterans Administration.

For reasons unbeknownst to us, some communities, and private sector corporations have constructed so many hospitals that now there is an excess of them in many areas, thus some are vacant. For several years, attempts have been made to pressure the Veterans Administration into purchasing or leasing certain of these facilities, rather than to build replacement hospitals or construct new facilities. There are several problems involved in such a venture. First, many if not most private sector facilities were not built to VA standards, needs or other specifications and requirements when they were constructed. Therefore, if VA did acquire such a facility, a substantial amount of renovation would be required prior to treating the first veteran patient. In addition, many times the vacant hospitals would not be located in an area in which it is feasible to establish a VA medical facility.

The American Legion feels that it is not the responsibility or the obligation of the Veterans Administration to purchase existing hospitals or other facilities from the private sector that are vacant or underutilized as a result of over-construction based on an enthusiasm for profit taking.

There may on the other hand, be instances in which a private facility would meet the needs and requirements necessary to establish a VA medical center or outpatient clinic, in which case we would reserve judgment until every aspect of the situation was thoroughly reviewed.

The next subject for discussion is the delegation of construction projects to VA medical center directors. The key issue in this regard is that the overall success of this initiative appears to be directly related to the abilities and attitudes of local VAMC directors and support staffs. The degree of acceptance, responsibility, knowledge, and dedication exhibited by these individuals regarding the delegated projects will most likely be the determining factors with respect to whether or not these projects are accomplished at the VAMC level in a timely and acceptable manner.

In 1981, Congress mandated that the Veterans Administration test a new approach to managing certain construction projects. The proposal specified that three VAMC directors be given the oversight authority for construction of three nursing home care units located in Ann Arbor, Michigan; Fresno, California; and Tampa, Florida. One of the main objectives in this study was to contrast and compare these three specifically delegated NHCU projects with seven comparable non-delegated NHCUs, from a period prior to delegation and during the same era in terms of time, cost, and quality of the construction project. As a result of the study, it was discovered that the three delegated construction projects had better performance outcomes than the seven non-delegated projects. The findings showed that the delegated approach can improve the schedule efficiency of the health care facility construction process, in projects the size and complexity of the NHCUs. Delegated construction projects resulted in a decreased time to complete working drawings, quicker award contracts, and completed projects in less time. A comparison by projects of average elapsed time in days showed delegated projects required an average of 259 days to complete working drawings, compared to an average time of 294 days for non-delegated projects; delegated projects averaged 43 days to award the construction contract, compared to an average of 101 days for non-delegated projects; and in reference to completing construction, average elapsed time was noted to be 584 and 718 days for delegated and non-delegated projects respectively.

Other advantages and strengths noted in this study were an increased user involvement in the construction process, greater user control over the entire process, and improved capability to follow through on problems.

Through Congressional mandate, 25 major construction projects have now been identified to be totally delegated to the local VA medical center level. Statistics and information resulting from this action should prove to be valuable guidance for VA concerning the entire construction program. Again it must be stressed that individual directors and their level of expertise, acceptance, and responsibility will play an important role in the final outcome of these projects.

The American Legion is supportive of this attempt to determine whether the delegated projects will lead to improvements in efficiency, and cost savings in the construction process.

The next subject that we have been invited to address relates to the provision of parking at VA medical care facilities.

At times the issue of adequate parking facilities at VA medical centers is given low priority as some feel that it is a minimal concern in the overall scenario of providing medical care to hospitalized veterans. However, The American Legion does not share that opinion.

In many instances, particularly in urban areas, adequate parking facilities can make the difference as to whether or not medical centers are able to recruit and retain qualified medical care professionals. Equally as important, the availability of facilities at which to park an automobile may be the determining factor as to a veteran's ability to seek and receive needed medical treatment. In addition, hospitalized veterans are entitled to receive visits by their families and friends. This is particularly important in the case of a veteran that is hospitalized with a terminal illness.

The American Legion is of the opinion that there is no substitute for satisfactory parking facilities. We are aware, through site visits by our Field Representatives, that parking problems at a number of VA medical centers are critical, and we would be pleased to share this information with the Committee upon request.

The next issue under consideration relates to the effects of Gramm-Rudman-Hollings on the FY 1986 medical construction funding.

The impact of Gramm-Rudman-Hollings Fiscal Year 1986 sequester order on construction projects equates to a cummulative reduction of $21,816,000 for major construction projects and $5,889,000 for minor construction projects.

The largest reduction is included in the Houston, Texas VA medical center replacement and modernization project, wherein $7,095,000 was sequestered from the 1986 appropriated amount of $226,800,000. The current estimated cost of this project, according to VA is $244,905,000.

A major project scheduled for VAMC, Philadelphia, Pennsylvania, which includes a clinical addition, renovation, parking, and a 240-bed nursing home care unit, has been reduced in the amount of $3,178,000 through sequestration. This amount, combined with recent reductions in funding for the parking facility, has created a potential problem regarding the completion of this project. As this Committee knows, this project will be accomplished in several phases. VA officials inform us that once the early phases of this project are underway, they will then be able to determine which aspects of the entire project can be further reduced. Although there may be the potential for VA to reprogram monies for total completion of this project, this is not a given fact considering the current fiscal climate. Minor adjustments can be accommodated, but any larger reduction in funding for this, as well as other major construction projects, may require VA to recycle some projects and redesign them at a lower level of work. The wasted time, effort and money that will result will far exceed any anticipated savings.

Several major projects involving fire and safety improvements, electrical improvements, and patient privacy issues are also being reduced in total funding through sequestration. Aside from the obvious concern The American Legion has pertaining to patient and staff safety in this regard, is the fact that many of these slated improvements are required by law through recommendations made by the Joint Commission on Accreditation of Hospitals or the Occupational Safety and Health Administration. Similar concerns are apparent when reviewing reductions in funding for major projects scheduled to address seismic deficiencies or asbestos abatement.

The seventh item for discussion is the Veterans Administration-Department of Defense resource sharing agreement.

The American Legion is not opposed to the proposed joint Air Force-VA sharing agreement of inpatient resources and programs at the Albuquerque VA medical center because of our continuous support of the Veterans Administration and Department of Defense sharing agreement concerning medical care resources. We recognize the particular benefits of increased interagency sharing. However, we do feel it necessary to ensure that no veteran with service-connected disabilities should ever be deprived of treatment in a VA medical care facility by reason of a VA-DOD sharing plan.

The American Legion will monitor the Veterans Administration-Air Force Agreement in New Mexico carefully inasmuch as this is the first effort of this kind that we are aware of in the VA system. If, through our monitoring, we identify any problems that are reported by our Field Representatives or The American Legion in New Mexico, we reserve the right to bring these problems to the attention of this Committee.

Mr. Chairman, the final topic for consideration by the Committee is S. 2141, a bill to prohibit the Administrator of Veterans Affairs from carrying out certain proposed real estate transactions. The American Legion is supportive of this legislation, which relates specifically to the efforts of the Office of Management and Budget to have declared as excess to the needs of the Veterans Administration, 46 acres of land at the VAMC Sepulveda, and 109 acres of land that are presently part of the complex that includes VAMC West Los Angeles.

We are most familiar with the situation at West Los Angeles, as we have been in consultation with The American Legion of

California on this issue for at least ten years.

The entire complex that comprises VAMC West Los Angeles, VAMC Brentwood, the VA Domiciliary and the National Cemetery operated by the VA Department of Memorial Affairs includes a total of 545.5 acres.

The original grant of the land that comprises these various VA activities was made in a deed executed by the owners of the land in the year of 1888. The land was gifted by the owners to the Federal Government to be used for the construction and operation of a Home for Disabled Volunteer Soldiers. Such a home was constructed and maintained, and through the years the original activity has changed, expanded and been modified until we see that today the entire complex comprises a variety of activities carried on by VA for veterans.

As the City of Los Angeles has expanded the land comprising the VA complex at West Los Angeles has become exceedingly valuable real estate. We can attest that all the VA land is coveted by the City of Los Angeles, by the University of California at Los Angeles (UCLA), and by developers who could make millions of dollars if they could gain control of that land, or any part of it.

The American Legion of California has long entertained an apprehension, shared by the National Organization of The American Legion, that sooner or later a move would be made to attempt to gain control of some or all of this land, as it is described in these paragraphs. We see in this initiative to transfer 109 acres of the land to GSA, the first move in this direction. The value of the land in Los Angeles County being what it is, and human avarice being what it is, there is no way some move would not be made to dispossess sick and disabled veterans from such valuable land to the end of putting a lot of money in somebody's pocket - here we refer to developers.

If the transfer proposed in this budget initiative is accomplished, we of the Legion have reason to believe that the heirs and descendants of the owners who gave the land to the U.S. for the specific purpose of caring for sick and disabled veterans may very well undertake court action to invalidate the original deed and reclaim the entire complex of land. The resulting value of such an action, if successful, would be profitable to the claimers beyond the wildest imagination of most of us.

The American Legion will continue to oppose the transfer of any portion of the land herein discussed to anybody, for any purpose other than to continue to provide care for veterans. We petition this Committee that the first thing that must be done is to obtain from appropriate legal authority an opinion on the language of the original deed of transfer of 1888, and an interpretation of the legal authority the United States may have, or may not have, to dispose of any portion of the land included in the original deed of transfer.

In addition to that, we wish to state for the record that the complex of land described herein encompasses a wide variety of activities for the care of perhaps the largest single concentration of veterans to be found in the nation. There is no possibility that the scale of veterans activities now being carried on at West Los Angeles will be in any way scaled down for the foreseeable future.

Mr. Chairman, thank you for this opportunity to express the views of The American Legion.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

DENNIS M. CULLINAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO

VA MEDICAL FACILITY CONSTRUCTION

WASHINGTON, DC APRIL 10, 1986

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for this opportunity to present the views of the Veterans of Foreign Wars of the United States with respect to issues pertaining to the Veterans Administration's medical facility construction. The VFW is appreciative of the Chairman for holding this hearing, demonstrating his and the Committee's ongoing concern in providing for the current and future health care needs of our Nation's veterans.

The VFW is very alarmed at the Administration's proposed construction budget for the VA's Department of Medicine and Surgery for fiscal year 1987 of only $408 million in new budget authority. This is a reduction of over $208 million from fiscal year 1986 and clearly demonstrates the Administration is willing to forsake this Nation's moral commitment to provide high-quality health care to its veterans now that demand is on the rise.

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As we all know, the entire American population is growing older on the average; however, the growth in the number of aging veterans is much more rapid. By 1990, veterans over the age 65 will make up more than one-fourth of the veteran population and by the year 2000 will have reached slightly over one-third. Further, the number of "frail elderly," those 75 years of age and older, in the veteran population will increase more than fourfold by the year 2000. This rapidly aging veteran population is placing a tremendous demand on all of the VA's resources and particularly its physical plant.

Considering that the health care needs of the aging veteran population will continue to increase and place an ever greater demand on the VA's delivery system, the Administration's proposed reductions in the VA's medical care construction authorization would serve to exacerbate a situation which is already critical and demonstrates what is, to our minds, a profound lack of sound judgment or commitment or both. The proposed authorization for fiscal year 1987 for the replacement and modernization activity is only about $212 million. This is a reduction of almost $189 million from fiscal year 1986 and would mean that the VA could not maintain even its current physical structures. This particular area has suffered for years from under-funding and, for this reason, the VA is already unable to satisfactorily answer the needs of the veteran population. This is born out inasmuch as 37,000 veterans a month are being denied health care at this time. Fifty-three percent of all VA beds are housed in buildings which are 30 or more years old. It can readily be seen that, unless the construction program is quickly and substantially enhanced, the shortage of space will rapidly worsen. Reducing this program--as is being proposed by the Administration--would spell disaster.

In this regard, it is inconceivable that the Adminstration would propose reducing the authorization for VA nursing home construction from $22.5 million in fiscal year 1986 to only $4 million in fiscal year 1987. This paltry funding level will result in all new VA nursing home projects being cancelled.

Similarly, it may only be viewed as appalling that no new funding is to be provided in fiscal year 1987 for VA domiciliaries. This is the sorry consequence of a new Office of Management and Budget [OMB] mandated policy which directs the VA to shift the responsibility for VA nursing home care to state and community facilities. This OMB policy is especially callous in light of the fact that the need for such facilities is now sharply on the rise and that state and community resources in this area are already overburdened. A sudden large influx of elderly veterans into these systems could well occasion their collapse.

The VFW applauds the proposed increase of over $21 million in budget authority for grants for construction of state extended care facilities which would set the authority for this program for 1987 at over $42 million. We appreciate that this would assist the VA in reducing the number of backlogged applications on hand from the states and should result in more extended care beds being available sooner.

Even so, we would point out that such a large increase in funding may result in the inefficient utilization of precious funds. One problem is that states are often hard put or reluctant to secure the necessary funding for building such facilities even with the availability of federal money. Further, it is also apparent that the Administration and OMB, through pursuing such a course, are attempting to escalate the privitization of veterans' health care. This, to our minds, will very swiftly result in fewer and fewer veterans provided with less and less health care. What is more, it is our fear that this push toward the wholesale privitization of veterans' health care is a ploy to transform this Nation's largest integrated health care system into a mere bureaucracy tasked only with the dispensing of vouchers and the cursory orchestration of very meager veterans' services.

With this in mind, we point with alarm and grave concern at the proposed diminishment of the VA's major construction activities funding along with the proposed reduction of over $24 million in its minor projects' authorization. In sum, such a low level of funding would constitute a severe blow to the VA's health care system.

The Veterans Administration's Department of Medicine and Surgery's most fundamental concern must be the provision of first rate health care to this Nation's veterans. Thus, its primary involvement must be directly related to health care. However, in order to provide veterans with this "top notch" care, the Department of Medicine and Surgery must have a modern physical plant capable of fully accommodating modern innovations and technology.

This brings us to focus on the proposal to reorganize the VA's construction planning process and organizational structure. This plan encompasses transferring the Office of Construction to the Department of Medicine and Surgery resulting in the Chief Medical Director (CMD) having full accountability and responsibility for the agency's construction program. A new Office of Facility will be created by combining the existing resources, staff, and functions of the Office of Construction and DM & S's facility engineering, planning and construction office. The VFW is of the opinion that if properly conducted, bringing VA health care facility construction under the direct control of the Chief Medical Director should provide for a more effective use of resources in delivering health care services and, thereby, increasing overall VA effectiveness. While effective management of staff resources may be viewed as being very critical, effective management of facilities, equipment and supplies, is certainly of equal importance to the proper delivery of health care services to veterans. As is pointed out in the Booz, Allen & Hamilton study on the VA's method of constructing health care facilities, highly integrated efforts between health care program management and health care resources are required for the VA to effectively accomplish its mission.

Thus, we support bringing the VA construction program directly under the Chief Medical Director's control so long as certain concerns are met. For one, we are apprehensive that the Department of Medicine and Surgery will run into problems by having to manage not only its own construction program, but also those of the Department of Veterans' Benefits (DVB) and the Department of Memorial Affairs (DMA). These two Departments already have many small construction projects in their 1987 budget requests and they also are involved with a great deal of leasing.

A fundamental concern is with the method in which the proposed reorganization is to be implemented. The Booz, Allen & Hamilton report clearly states that first the current level of integration between the construction program and the health care program must be made in two general areas: one, construction policies and procedures are needed that provide greater consistency with those of the health care program, and, two, organizational functional alignments are needed that reduce coordination requirements between the two processes. Only after this has been accomplished should the reorganization of responsibilities for carrying out the health care facility construction process take place. It certainly makes sense to us that the implementation of process reform comes before structural reorganization. We fear that not enough effort is being invested in decerning and implementing critical process changes and that too much emphasis has been placed on changing the orgnizational structure. Simply shifting about management and oversight responsibilities will not result in more effective resource allocation unless the data base and facility development plans have been carefully developed and clearly described in advance. In other words, it is essential to first determine what the Department of Medicine and Surgery's construction project goals are and how they are to be achieved before deciding who should go about doing it.

Careful and consistent planning will be essential in designing an effective overall VA construction strategy. In this regard, the Booz, Allen & Hamilton Report points at a direct involvement between Medical District Initiated Program Planning (MEDIPP) and individual VA medical center facility construction needs. It is our understanding that at this time the VA construction planning processes, including long-range strategic planning, is both inconsistent and ineffective. This means that the adequate assessment or proposed medical facility mission changes and of utilizing the means of purchasing or leasing already existing private sector facilities is virtually impossible. Thus, the VFW may only comment on these means of providing health care to veterans on a case-by-case basis.

The VFW views the delegation of VA construction projects to individual VA medical center directors as being an inadequate means of addressing the shortcomings of the current construction planning system. In short, this is not so much an attempt at a solution as at a quick fix. It most certainly does not represent the comprehensive solution to the planning, design and construction problems recommended by the Booz, Allen & Hamilton study.

In concurrence with this study, the VFW is convinced that the VA Central Office must maintain responsibility in the planning, designing and construction process in order to ensure consistency of care at all VA Medical Centers.

The VA Central Office should serve as a repository of accumulated data and information from throughout the system so as to maintain and develop standards and criteria appropriate to all individual medical facilities. Delegation would result in the further deterioration of the feed-back mechanisms and other controls that are essential for the development and maintenance of consistently high agency standards. Taken separately, VA Medical Centers deal with few major construction projects and are, therefore, not well prepared to contend with the conceptual, contractual and design problems inherent in such undertakings. But with all the VAMC's taken as an aggregate, with the proper feed-back and control mechanisms in place, the VA construction program will be able to not only successfully meet its own construction needs, but to also design and develop a construction model to meet the rapidly growing demand for health care throughout the entire Nation.

With respect to Gramm-Rudman-Hollings, it is our considered opinion that the entire VA, including its construction program, should be exempt from reductions pursuant to sequestration. It is very apparent that the VA construction program is already strained to the limit and cannot successfully tolerate any further cutting. The recently mandated cut of 4.3 percent had an especially adverse impact on projects that are already well under way, since this sudden, unexpected reduction necessitated expensive, last minute design changes. In light of the fact that it has been estimated that the next sequestration order may be as high as 30 percent, we view it as essential to exempt the VA construction program.

With respect to the VA and the Department of Defense sharing medical care resources, the VFW believes that such arrangements may well benefit both the Veterans Administration and the military. We will be closely watching the pilot project between the Air Force and the VA in Albuquerque, New Mexico wherein a portion of one floor, approximately 40 beds, will be reserved for Air Force use and staffed by Air Force personnel. This project would seem to be in keeping with Public Law 97-174, the VA and Department of Defense Health Resources Sharing and Emergency Operations Act. Hopefully this project will serve to provide those special services not usually found in either Air Force or VA Medical Centers alone.

With respect to S. 2141, a bill to prohibit the VA from declaring as excess several parcels of land at VA Medical Centers in Southern, California and then allowing them to be disposed of by the General Services Administration (GSA). In general, the VFW has assumed an extremely cautious position with respect to selling any VA lands. To our minds, it is essential that an absolute determination first be made that any such land will not eventually be needed by the VA. It must be known for certain that such land will not, for example, one day be needed for construction of a VA Regional Office or the expansion of a medical facility. What is more, it is also essential that it be ascertained in advance what use such land will put to. It is one thing for a park or recreational center to be constructed near a VA hospital; it would be quite another if an industrial plant was suddenly erected across the way from a veterans' hospital. One must also not lose sight of the fact that urban hospitals require a buffer zone around them so as to provide sick or incapacitated veterans with a satisfactory living environment. In many cases, we believe it would be advisable to utilize a long-term leasing arrangement rather than to declare excess and dispose of VA land out right.

With respect to the land in question in S. 2141, the VFW holds that if this property were to be sold, the VA would be deprived of the necessary lattitude for expansion in the future. Also, it is our understanding that the land in question at the Veterans Administration Medical Center located in West Los Angeles is not free and clear and that costly litigation could ensue if the VA were to attempt to sell this property. Additionally, it is our opinion that the VA will, in fact, need this land in the not so distant future. We are also opposed to selling the 46 acres of land at the VA Medical Center in Sepulveda, California. We cannot see how this would be in the veterans' best interests. Therefore, S. 2141 enjoys VFW support.

Mr. Chairman, a germane resolution adopted by the voting delegates to our most recent National Convention is appended to my testimony.

Thank you and I will be happy to respond to any questions you may have.

Resolution No. 717

VETERANS' HEALTH CARE

WHEREAS, Congress on July 21, 1930, established the Veterans Administration health care system and progressively increased their responsibilities to administer veterans' benefits; and

WHEREAS, attempts are now being made to drastically alter and reduce veterans health care (long and short term) benefits through budgetary constraints such as "mainstreaming" veterans away from veterans facilities into the private sector; barring veterans with nonservice-connected disabilities from eligibility or eliminating construction and maintenance of hospitals, domiciliaries, nursing care homes/units; reimbursing the VA from third parties; reducing VA staff and regionalizing; and

WHEREAS, the VA cuts in the health care system will not only affect the veterans, but also their dependents and all political, economic and social lines; and

WHEREAS, with the demographic increase of the aging veteran population plus younger veterans, the quality of comprehensive health care in a VA facility is unparalleled, and is no more expensive than other federal health care programs and less expensive than private systems to care for all needy veterans (long and short term); now, therefore

BE IT RESOLVED, by the 86th National Convention of the Veterans of Foreign Wars of the United States, that we support maintaining federal funding for the VA health care system benefits for ALL veterans, plus increasing VA health care facilities (hospitals, domiciliaries and nursing care homes/units) to provide long and short term care due to the increasing needs of the aging and younger veterans.

Adopted by the 86th National Convention of the Veterans of Foreign Wars of the United States held in Dallas, Texas, August 16-23, 1985.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
OF THE
UNITED STATES SENATE
April 10, 1986

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the over one million members of the Disabled American Veterans and its Ladies' Auxiliary, I would like to take this opportunity to thank you and the members of the Committee for allowing us the opportunity to present our views on the Veterans Administration's medical construction program.

In your letter of invitation to testify, our views were solicited on the major policies pertaining to VA medical facility construction, as well as a number of relevant issues pertaining to the construction program.

Before specifically addressing these issues, Mr. Chairman, we believe that it is important to place the Veterans Administration medical care program -- Department of Medicine and Surgery (DM&S) -- in its proper context to the delivery of health care, in general, and to veterans, in particular.

The stated mission of DM&S is "to ensure that quality medical care is provided on a timely basis within the law to all authorized veterans."

This mission is formulated to provide:

* a complete medical and hospital service for the medical and hospital care of veterans;

* a program of education and training of health care personnel;

* a program of medical research; and

* health care services to members of the Armed Services during war or national emergency.

Medical Services

Presently, Mr. Chairman, the VA's health care system is comprised of 172 medical centers, 227 outpatient clinics, 110 nursing home units and 16 domiciliaries.

Within current statutory framework, the VA is authorized to furnish medical treatment to:

1. any veteran for a service-connected disability;
2. any veteran (for any disability) who has a service-connected disability rated at 50% or more;
3. former prisoners-of-war;
4. veterans entitled to nonservice-connected pension;
5. World War I, Spanish American War and Mexican Border Period veterans;
6. Vietnam veterans exposed to certain herbicides, i.e., Agent Orange;
7. veterans exposed to ionizing radiation (atomic veterans);
8. any veteran 65 years of age or older for a nonservice-connected disability; and
9. any veteran for a nonservice-connected disability if unable to defray the costs of necessary treatment.

Contrary to the varied assertions voiced by a variety of individuals and sources, the VA medical care system has, is, and will continue to treat veterans who are, in the vast majority, service-connected and/or medically indigent. Only one in nine veterans -- slightly more than 10% of the estimated 28 million living veterans -- have ever availed themselves of VA medical care.

Mr. Chairman, it seems abundantly clear, for a variety of reasons, that the VA is correct in its estimation that of the 12 million veterans (service-connected, those in receipt of nonservice-connected pension, those age 65 or over, or those who are unable to defray the cost of private medical care) eligible for VA medical care and treatment, only a portion will access into the system during their lifetime.

Clearly, fiscal constraints and finite federal dollars, in conjunction with established priorities and the freedom of choice of some veterans to receive medical care elsewhere, have dictated and will continue to dictate how many veterans enter the system.

The VA will treat, on an inpatient basis, an estimated 1,247,667 veterans in Fiscal Year 1987, representing a decrease of some 58,000 from Fiscal Year 1986. Approximately 22,300 veterans (an increase of only 733) will be treated in VA nursing home care units while maintaining an average daily census of 10,972 (an increase of only 380) over 1986 levels. Additionally, 16,676,000 outpatient medical visits are estimated to occur in Fiscal Year 1987 (a decrease of over 1.1 million from the Fiscal Year 1986 level).

Mr. Chairman, from Fiscal Year 1976 ($3.7 billion) to Fiscal Year 1986 ($9.4 billion), the VA health care budget has more than doubled in total actual dollars. However, once deflated to reflect movement in the Consumer Price Index, we view a virtually solid straight-line budget.

Additionally, a comparison of VA health care dollars as a percent of the total federal outlays for health, medicine and veterans hospital and medical care reveals a decline from 11.4% of total outlays in Fiscal Year 1977 to an estimated 8.5% in

Fiscal Year 1987.

On average, VA patients are older, have lower incomes, have less health care insurance, and are often in need of specialized and more comprehensive type care than their counterparts in the general population. Also, VA inpatient services are intrinsically linked to outpatient services and specialized modalities of treatment.

The above, Mr. Chairman, illustrates, albeit briefly, the general scope, responsibility and workload encompassed in the VA medical care program. Suffice it say, that the VA's Department of Medicine and Surgery is the nation's largest integrated comprehensive, total medical care system in the country. It is the only system capable of providing a full array of health care services to this nation's eligible, disabled veterans.

Education and Training

Mr. Chairman, each year nearly 100,000 students receive some or all of their clinical training in VA facilities through active affiliations with over 1,000 educational institutions.

In Fiscal Year 1984, the VA supported approximately 7,800 full time medical residency positions under affiliations with 101 medical schools. Special emphasis was given to supporting programs in psychiatry, anesthesiology, geriatrics, radiology and physical medicine and rehabilitation. Through similar arrangements, VA facilities also provided clinical education experience for undergraduate medical students.

To meet the special needs of veterans and to provide national leadership in the areas not adequately addressed by existing training programs, specialist physician fellowship programs exist within the VA. These include fellowship programs in geriatrics, spinal cord injury, substance abuse and geriatric dentistry.

It is clear, Mr. Chairman, that the VA conducts the health profession's largest coordinated education and training program in the country.

Research and Development

Mr. Chairman, the VA's research and development programs continue to make significant contributions toward fulfilling the VA's charge to provide veterans with the best possible health care. These contributions have been made possible by a long-standing policy of linking VA medical centers with major medical schools and encouraging clinical and non-clinical investigators to study the wide variety of health care issues prevalent to veterans.

The VA's medical research service has been instrumental and remains active in creating new medical knowledge and breakthroughs in such areas as treatment of mental illness, hypertension, kidney disease, the effects of aging, spinal cord injuries, tissue regeneration, health problems of female veterans and former prisoners-of-war and the effects of exposure to Agent Orange and post-traumatic stress disorders primarily among Vietnam veterans.

Mr. Chairman, the mission of the Rehabilitation Research and Development (RR&D) Service is to improve the quality of life for impaired, disabled and handicapped veterans by making them more functionally independent. This mission has been significantly advanced by ongoing research and development projects in established priority areas of prosthetics/amputation, spinal cord injury and sensory aids.

Major, ongoing research is being conducted in the areas of developing a new generation of artificial limbs that will be lighter, better fitting and more functional to permit greater natural movement and participation in a wider variety of vigorous activities for amputees.

The use of robotics and computer controlled electrical stimulation to restore some function to paralyzed limbs are constantly being explored in order to make the spinal cord injured veteran more independent.

The development and practical utilization of advanced aids for the blind and hearing impaired veteran are also high priority areas that the VA is engaged in with promising findings and results being noted.

The Health Services Research and Development (HSR&D) Service is dedicated to improving veterans' health care by evaluating alternative medical interventions and policies that enable VA clinicians and administrators to make intelligent and efficient health care decisions and choices.

It has recently come to our attention, Mr. Chairman, that a decision has been made to transfer the functions of HSR&D from the Assistant Chief Medical Director for Research and Development to the office of the Assistant Chief Medical Director for Planning, Coordination and Systems Development.

The DAV has not been officially advised by the VA of the planned transfer of functions. Therefore, we do not wish to comment specifically at this time.

We do, however, want to offer our opinion that HSR&D activities, both in Central Office and its field programs, have contributed significantly to the VA's ability to provide quality medical care.

Mr. Chairman, our major concern is that HSR&D will be able to continue to function and engage in meaningful projects that will further enhance the VA's ability to provide quality and efficient health care.

It can be accurately stated that the VA's medical, rehabilitation and health services research efforts have helped the VA keep pace with and, in many instances, set the standards for modern, quality health care in this country.

Veterans Administration/Department of Defense Health Resources Sharing Program

As you are aware, Mr. Chairman, Public Law 97-174, the -- Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act -- mandates the VA to serve as the primary health care back up to the Department of Defense (DOD) in the event of war or national emergency. Additionally, this Act provided new and expanded opportunities for the sharing of health care resources between VA and DOD.

At the end of Fiscal Year 1985, 201 sharing agreements were in effect between the VA and military hospitals. Ninety-two military medical facilities had entered into at least one agreement with 79 VA medical centers.

The scope of sharing agreements include cardiac and a variety of other surgical services, a vast array of inpatient and outpatient general medical services, treatment of spinal cord injuries, pathology, dietetics and dental service.

Additionally, many non-direct patient care services are performed on a sharing basis to include laundry and library services.

As you are aware, Mr. Chairman, a major milestone regarding VA/DOD sharing agreements was reached on January 21, 1986, with the signing of a Memorandum of Understanding between the VA and the Air Force.

This action resulted in the approval of a VA/DOD demonstration project consisting of a joint venture hospital sharing agreement to be implemented at the Albuquerque, New Mexico VA Medical Center.

As we understand the agreement, VA will lease to the Air Force up to 40 beds for the inpatient care of active duty and retired military personnel, as well as dependents and those individuals eligible for CHAMPUS.

Additionally, the Air Force will reimburse VA for the provision of specialized medical and/or ancillary services.

Mr. Chairman, this agreement is certainly innovative and appears to impart a beneficial effect for both the VA and DOD.

While the DAV has no overall objection to this type of sharing agreement, we would caution the VA to pay particular attention and insure that no veteran -- especially service-connected veterans -- are denied or postponed needed medical services in order to accommodate Air Force personnel and/or other eligible beneficiaries.

Mr. Chairman, in our opinion, the delivery of quality health care to this nation's disabled veteran population entails a commitment to modern, safe and efficient medical care facilities.

To fulfill this commitment, it is necessary that the VA provide, on an continuing basis, for the reasonable expansion, renovation, modernization and replacement of its medical facilities.

To do less, Mr. Chairman, would, in our view, jeopardize and ultimately dismantle the VA system. Without active affiliations in programs of education, training and research efforts -- which serve as highly successful vehicles to attract quality health care providers -- the quality of care provided by the VA would not exist to the potential necessary to make the system viable.

The Congressional mandate that the VA act as the primary source of medical care back up to the Department of Defense would be, for all practical purposes, nullified absent medical construction funds to maintain the physical plant facilities of the VA's approximate 5,000 separate buildings.

Fiscal Year 1987 Construction Budget

As you know, Mr. Chairman, the VA's Fiscal Year 1987 program level request for construction is $465 million, some $332 million below the Fiscal Year 1986 level. The proposed budget would reduce funding for medical facility construction by approximately 41% from the Fiscal Year 1986 budget, a decrease of $208.4 million ($184 million in major projects and $24 million in minor projects).

Of the total program level, approximately $423.5 million will be devoted to the health care system.

Highlights of the medical construction program include:

- $212.4 million for replacement and modernization projects;
- $44.7 million for general and miscellaneous projects to accomplish certain renovations, modifications, remodeling and other general improvements for support systems;
- $94.6 million for clinical improvements;
- $10.4 million for fire and safety improvements;
- $4 million for nursing home improvements;
- $1.5 million for outpatient improvements;

- * $19 million for the design fund; and
- * $5 million for the advanced planning fund.

Mr. Chairman, a review of the VA's Fiscal Year 1987 construction request for medical programs reveals that the agency's ability to provide quality care is being placed in jeopardy.

Simply stated, while we support full funding of the proposed construction program, we are nevertheless concerned, not only with the quality of care currently being provided, but also about the VA's ability to meet the pressing demands being placed upon the health care system.

The DAV is concerned, as I know you are, Mr. Chairman, with how the VA will provide quality health care to the rapidly increasing aging veteran population.

According to VA statistics, there were three million veterans age 65 and older in 1980, constituting 10.5% of the total veteran population. By 1990, this figure is expected to rise to 7.2 million, representing 26.6% of the total and by the year 2000, the number will reach nine million, translating to 37% of the veteran population.

We know that greater numbers of elderly veterans are seeking nursing home care from the VA, yet, of this medical construction budget, less than 1% ($4 million) is requested for nursing home care bed construction, conversion, renovation and relocation.

Furthermore, while more and more elderly veterans are seeking nursing home care from the VA, this construction request reflects a new OMB mandated policy which directs the VA to shift the responsibility for VA nursing home care to state and community nursing facilities. As a result, all new VA nursing home projects have been proposed to be cancelled.

We do support the VA's proposal to convert 59 hospital beds to nursing home care beds. However, as demand for nursing home care beds rapidly increases, we would urge the VA to direct greater attention to the conversion of beds already closed (or to be closed) to nursing home care beds. While the VA is considering the conversion of these few acute care beds within hospitals, we view their future plans to be directed more at a change of mission, i.e., conversions of entire hospitals.

Mr. Chairman, the DAV will not, in every instance, oppose the VA's plans to change the mission of certain VA hospitals. However, as the demand rapidly increases for nursing home care beds, we would urge the VA to proceed on a swift timetable concerning conversion of beds, while maintaining an appropriate balance to meet the acute and intermediate health care needs of all veterans, including the aging veteran.

Mr. Chairman, OMB and the VA have clearly circumvented the law (Section 5010(a)(1), Title 38, United States Code). In Fiscal Year 1986 the VA will operate with 1,800 fewer beds than that which is required by law and it is projected that in Fiscal Year 1987 bed levels will drop 4,000 below statutory requirements.

The DAV has an inherent interest in the maintenance of VA hospital beds for the care and treatment of all eligible veterans. Yet, the Fiscal Year 1987 budget projects the loss of 2,700 hospital beds. This reduction will bring the total loss of hospital beds within the confines of the system to 5,900 since 1982. Conversely, the VA has added only 2,600 nursing home care beds to the system over the same period, a net loss of 3,300 beds since 1982.

As you know, Mr. Chairman, the Medical District Initiated

Program Planning (MEDIPP) is used as a plan to assess the system's future needs based upon a medical district prospective and the shift in veteran population.

Additionally, MEDIPP is capable of assisting in the construction program by integrating grass roots, programmatic planning; developing early conceptualization of facility construction needs; and by expanding the flexibility of space criteria to meet changes in mission requirements.

Mr. Chairman, the DAV supports the facility planning concept embodied in MEDIPP -- making the most cost-effective use of resources and funding that is available. The program should not only continue to provide input in the construction planning process but the involvement of individual medical center directors should be intensified during virtually all phases of the process.

The VA's Fiscal Year 1987 construction request includes $5 million for the Advanced Planning Fund (APF). As we understand it, the APF is designed to provide flexibility to explore various corrective strategies, propose alternative conceptual approaches and enable informed decisions to be made.

Additionally, the VA is requesting $19 million in Fiscal Year 1987 for the design fund. This fund, with certain restrictions, permits the VA to initiate working drawings for construction projects prior to final Congressional approval for funding. By using this process, the VA has estimated an average delay of 15 months may be eliminated, thereby producing savings to the VA by the avoidance of additional inflationary cost.

Mr. Chairman, if in fact the flexibility provided by the APF is present and beneficial and taxpayer dollars are saved by eliminating unwarranted delays as suggested by the mechanics of the design fund, then the DAV can support full funding of these items in the construction budget.

Grants for Construction of State Extended Care Facilities

As you are aware, Mr. Chairman, this program provides grants to assist states to acquire or construct state home facilities for furnishing domiciliary or nursing home care to veterans and to expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home or hospital care to veterans in state homes.

Under the current program, a grant may not exceed 65% of the total costs of the project and grants to any one state may not exceed one-third of the amount appropriated in any one fiscal year.

The VA's Fiscal Year 1987 appropriation request of $42.4 million will provide for an additional 120 nursing home, 126 convertible and 150 docmiciliary beds.

Without question, Mr. Chairman, the domiciliary, nursing home and hospital care provided to this nation's veterans by state veterans homes has been invaluable in terms of offsetting the severe losses suffered by the VA's health care system as discussed earlier.

During Fiscal Year 1986, state veterans homes will maintain an estimated average daily census of 8,434 nursing home, 4,516 domiciliary, and 512 hospital patients. In Fiscal Year 1987, state nursing homes', domiciliaries' and hospitals' average daily census is projected to increase by 402, 68 and 5, respectively.

Recognizing the significant and important role of state veterans homes -- in terms of care provided to the rapidly aging veteran population and the cost effective use of federal taxpayer dollars that supplement this program -- we believe it is indeed wise to continue funding this program that ultimately produces savings to the government in terms of both construction and health care costs.

The DAV has always been supportive of the VA's medical construction program. However, the fact is that the capital plant of the VA health care system is deteriorating and will continue to do so at a rapid pace. One reason for this deterioration is, in our view, that the VA is attempting to play "catch up" with respect to renovations due to what could be classified as severe under funding over a long period of time.

Mr. Chairman, this budget request simply does not go far enough to allow the VA to accomplish what it must accomplish if the system -- which represents a multi-billion dollar investment on the part of the American taxpayer -- is to remain viable.

As you are well aware, Mr. Chairman, there has been considerable concern voiced over the VA's process of prioritizing major construction projects. As a result, via the 1985 appropriation process, the VA was directed to develop a new and meaningful prioritization process (which it has accomplished).

The DAV certainly supports this concept in theory. By establishing a methodology to prioritize and give emphasis to certain kinds of projects, i.e., nursing homes, clinical, fire/safety renovations, etc., which are felt to be of relative importance over other projects, the needs of veteran beneficiaries will, in our view, be best served.

Mr. Chairman, we are pleased that the VA is attempting to develop a prototype nursing home design that can be adapted to different terrain across the country and insure uniformity, as well as reduce the cost of nursing home construction.

However, Mr. Chairman, we are aware of a recently completed audit by the Office of Inspector General which discovered serious flaws in the development of an acceptable prototype nursing home care unit.

These flaws resulted in a conclusion that the VA has not yet accomplished its major program initiative of developing a nursing home care unit prototype that provides quality, timely and cost-effective facilities to meet the long term care needs of aging veterans.

Mr. Chairman, the DAV believes that the initiative to develop this prototype is significant and necessary. We also believe, however, that it is time for VA program officials at VA Central Office and DM&S field officials to come together and make the firm and conclusive decisions that will ultimately produce a realistic prototype nursing home care unit that can be utilized as originally conceived in theory.

Reorganization

As you know, Mr. Chairman, on October 31, 1985, then Administrator Harry N. Walters announced the agency's intention to transfer the Office of Construction into the Department of Medicine and Surgery.

The stated purpose of the reorganization was to streamline the operations of the VA's construction process by reducing functional duplication, eliminating conflicting roles and to fix accountability in one organization.

The decision to propose such a reorganization concerning the medical facility planning, design and construction program resulted from a comprehensive study -- at a cost of nearly $1 million -- conducted by Booz, Allen and Hamilton and RTKL Associates.

As stated by the VA, the study had three goals:

* to determine, consistent with the health care mission of the VA, the most effective and efficient internal organization and procedural structures for defining, developing, designing, constructing, maintaining and improving medical and health care related capital facilities of high quality, consistent with resource and timeliness considerations;

* to assist the VA in evaluating the appropriateness, effectiveness and efficiency of its current organizational and procedural structures for the functions described above; and

* to implement, if appropriate, innovative, practical alternatives to the VA's current organization and procedures for delivering health care facility construction programs by means of fully supported recommendations for change.

In short, Mr. Chairman, the study identified major weaknesses in policies, procedures and organizational responsibilities that resulted in poor coordination between the construction and medical care programs.

The study found and recommended that a major step toward full integration between the health care program and the construction program could occur by establishing: (1) DM&S Central Office as the manager of the health care facilities construction program; (2) the Office of Construction as the provider of technical support and major construction design and construction manager; and (3) the various VA medical centers as project managers and managers for minor construction projects. Additionally, it was concluded and recommended that the consolidation of all process oversight responsibility should be placed in the Controller's office.

Mr. Chairman, while we agree, in concept, to the need for a reorganization of the Office of Construction, we would urge the VA, in so doing, to truly streamline the process and eliminate the identified weaknesses and fragmentation while simultaneously forming a cohesive unit that will best serve the health care needs of the Veterans Administration and, ultimately, disabled veterans.

Mr. Chairman, we believe it important to point out, in our opinion, that the driving force behind the Fiscal Year 1987 construction budget -- indeed the entire VA budget -- is the Gramm/Rudman/Hollings balanced budget amendment. Not only has Gramm/Rudman/Hollings influenced the makeup of the Fiscal Year 1987 budget request, but it has also inflicted direct benefit reductions on deserving service-connected disabled veterans, their dependents and survivors in the current Fiscal Year.

We believe the VA has been short-sighted in their decisions regarding sequestering of funds in various programs -- the construction program included.

As we understand it, a 4.3% sequestering of major construction funds -- $21.8 million -- was applied across-the-board affecting 31 individual ongoing projects. While the VA states that no significant impact or slippage will occur in any individual project, we are, nonetheless, concerned that the opposite will occur.

It seems to us, Mr. Chairman, that should a sequestering of funds in the construction program be necessary in future years, the VA may more judiciously apply those provisions by withholding funds from some lesser priority projects to insure that all other projects will not suffer delay and, ultimately, cost increases to the federal government.

Mr. Chairman, I would like to take this opportunity, on behalf of the entire membership of the DAV, to commend you, as well as another distinguished member of this Committee, Senator DeConcini, for your efforts in introducing separate measures which propose to exempt certain benefits of service-connected disabled veterans, their dependents and survivors from any future sequestration actions resulting from Public Law 99-177 -- The Balanced Budget and Emergency Deficit Control Act of 1985.

S. 2141

Introduced by the distinguished Ranking Minority Member of this Committee, Senator Cranston, this measure proposes to prohibit the VA from declaring excess -- and thus dispose of -- certain parcels of land located at the VA Medical Center West Los Angeles, California (consisting of approximately 109 acres) and the VA Medical Center Sepulveda, California (consisting of approximately 46 acres).

Mr. Chairman, this measure was introduced in response to an Administration Fiscal Year 1987 budget proposal that would permit the disposing of such property by the General Services Administration under government-wide disposal guidelines. According to the Administration, sale of that land would generate an estimated $360 million in revenue to the government.

The DAV supports S. 2141.

Mr. Chairman, this proposal is, most definitely, one initiated by OMB and not the VA. Our primary concern relates to the Administration's obvious desire to establish and initiate a system-wide policy within the VA of disposal of VA property, primarily at VA medical centers, that very well could be -- and probably will be -- contrary to the best interests of individual medical centers and the system as an entity.

In the instant case, there are numerous reasons that compel us to oppose the excessing of this land. These include the obvious legal implications involved and litigation that is sure to ensue, coupled with the apparent reduced fair market price that would occur as a result of such legal action. Certain local encumbrances and perceptions from the community further portray this as an ill-conceived proposal. Additionally, and perhaps most importantly, the VA has stated its belief that it needs the land for the purposes of patient utilization, as well as possible expansion relating to various agency needs.

We therefore urge the Committee to favorably consider and so report S. 2141.

Delegation of Construction Projects

As you know, Mr. Chairman, the Congress has directed the VA to test a different approach to managing certain construction projects by delegating, to individual medical center directors, the authority for major construction projects at individual medical facilities.

In our view, Mr. Chairman, the concept of delegation serves a number of beneficial purposes, foremost of which is the ability of the individual facility management team to become personally and intimately involved in the planning process, from the time of conceptualization of the project through the completion of the finished product.

However, in our opinion, it would be most unwise to delegate to medical center directors a "blanket authority" for all major construction projects.

We feel that the perceived basic intent of the decision to implement such delegation of authority can easily be achieved by VA Central Office's commitment to more actively involve, from the time of conceptualization of a specific project, the affected medical center personnel. Such a course of action should be adequate enough to assure that the facility's needs are met in the most effective fashion.

This approach, combined with VA Central Office's involvement concerning support, technical assistance and the responsibility for the actual physical construction of the project, will assure proper integrity of the medical facility construction program.

In closing, Mr. Chairman, we commend the Committee's recent action in recommending the addition of $35 million in construction funds for high priority projects such as nursing homes, clinical improvements and the correction of various deficiencies, including fire and safety projects.

Mr. Chairman, this completes my testimony, and I want to again thank you for allowing us the opportunity to share our views regarding the VA's medical construction program.

Statement of

DAVID J. PASSAMANECK

AMVETS National Legislative Director

Before The

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

On

Veterans Administration Medical Facility Construction

0930, 10 April 1986, SR-414

Mr. Chairman, AMVETS is pleased to address the proposed Fiscal Year 1987 plans for Veterans Administration medical construction.

In the summer of 1980, when President Reagan was running for the office, he inspired the veterans' community in an address to a national veterans organization convention in Boston, by promising that the earned entitlements of veterans and their dependents and survivors would not be undermined, regardless of his commitment to reducing the excesses of government spending and an ever increasing tax burden. At the same time, the President clearly set forth a basic principle of his philosophy of government, when he stated, as he did again in his State of the Union Address this year, that the most important function of government is to defend its citizens from the aggressive purposes of foreign enemies. Although the President has declared his awareness of the special status of veterans in our society, his administration has repeatedly failed to recognize that the programs established for the rehabilitation and benefit of those who have "borne the battle" are an integral and morally compelling part of the cost of national defense, as much as the cost of current military hardware. Although the defense and veterans budgetary categories are technically separate, the Veterans Administration's budget cannot be lumped together with other domestic programs not related to the powers and responsibilities of national defense. The President has rightfully and courageously advocated the continued recovery of our defense capability, tragically weakened in the wake of the shameful sell-out of our ally and over 58,000 of our fighting men and women in Viet Nam. However, when it comes to paying the solemn debt we owe as a nation to those who came back from that war and the World Wars and Korea as well, the special earned place of veterans is forgotten.

Almost from the inception of this Administration, the voices of fiscal conservatism, exemplified by the Grace Commission, have been calling for what amounts to the dismantling of the Veterans Administration and the essential services it provides for veterans and their families. In addition to the privatization of the finest medical delivery system in the world, the plans call for an almost total elimination of the contact, advisory, and adjudicative services upon which veterans must depend in securing those benefits which the law provides as well as elimination of all medical care for nonservice-connected veterans and eventually for those whose disabilities are not attributable to armed conflict or instrumentality of war.

AMVETS has consistently and enthusiastically supported the President's clear-headed leadership in the area of national defense. We are among the first of the veterans organizations to vigorously support the Strategic Defense Initiative, and we believe its increasing funding is the most vital imperative for our physical survival as a nation and for the survival of freedom in an increasingly hostile world in which we face the most ruthless, repressive and heavily armed adversary in history. We believe, as the President does, that to equate our defense requirements with the multifaceted mixture of often nonessential and unproductive government domestic spending ventures is to invite national suicide. By the same token, we refuse to accept the proposition that we can provide for an adequate national defense and at the same time betray the sacred obligations which we owe to our veterans, as well as our active and retired military personnel. Anyone who has the most superficial knowledge of military history, understands that ultimately wars are fought by people, and that if the legitimate needs of those who serve are ignored or forgotten, the most sophisticated machinery for the delivery of destruction to an enemy, or for our defense will avail us little. We are right now paying a terribly expensive price in terms of the continuous loss of trained military people to the private sector, not so much because of inadequacies of current compensation, as because of the demoralizing effect of promises and obligations to our veterans which are conveniently ignored in a misdirection of our otherwise legitimate efforts to cut the cost of goverment. So long as the President's defense policies do not include priority fulfillment of our obligations to our veterans, those policies are sadly inconsistent and to a considerable degree, self defeating.

In order to objectively assess the perilous condition in which we find our veterans' entitlement programs as we consider the VA budget for FY 1987, we must first recognize the complete breakdown of the national budgetary process, at least as a function of intelligent, discriminating and purposeful endeavor. This past October, AMVETS responded to the initial version of the Gramm-Rudman-Hollings Amendment in letters to Senators Gramm, Rudman and Hollings by stating:

> If the Gramm-Rudman-Hollings Amendment is designed as a serious response to the economic and political realities of the budgetary quagmire, then we are in worse trouble than even the most pessimistic of us had imagined. The amendment appears to be based on two premises: That if the Congress is politically incapable of controlling spending, then the ball should be passed to the President; and that, with the exception of Social Security, all other budgetary programs are of equal value. In addition to these fundamental assumptions underlying the Amendment, subsumed in its terms is a tacit acceptance of tax increases as a possible escape from the dilemma.

AMVETS, as we have repeatedly maintained in resolutions adopted by our national conventions and testimony before Congressional committees, strongly supports those policies which seek to control government spending, control inflation and interest rates, and perpetuate the economic prosperity which we are now enjoying. No segment of the population suffers more acutely from economic instability than veterans and their families, many of whom are dependent on minimally sufficient disability compensation and pensions. We have seen the disastrous impact that excess government spending and its attendant deficits has had on the usually depressed employment situation of our younger veterans.

However, we specifically reject the cynical concept that all government programs, except the politically untouchable, equally deserve to be cut in order to comply with a predetermined deficit limit.

Any program to control budget deficits which ignores the essential priority of expenditures for national defense, including veterans entitlements, is completely unworkable and constitutes a dangerous threat to our very existence as a nation.

The constant actual level of expenditures for veterans' entitlements has been steadily decreasing over the past decade, while most other government programs have literally gone through the ceiling. Completely unnecessary drains on the Federal treasury, such as the Synthetic Fuels Corporation, as well as the Energy and Education Departments, the elimination of which the President promised to seek in 1980, go marching on, but the benefits earned by those who have made the sacrifices demanded in the defense of their country are subjected to across-the-board economizing without any accounting for comparative merit.

AMVETS believes that veterans should come first in government funding and last when budgets are cut. It is unfortunate that the Gramm-Rudman-Hollings Amendment fails to subscribe to this basic standard of civic decency.

For Fiscal Year 1987, the Administration requests a VA budget authority of $26.6 billion, which is about $408.4 million below the current estimated authority for FY 1986, notwithstanding a proposed 3.7 percent cost-of-living increase for compensation, pension and DIC, effective December 1, 1986. Under Gramm-Rudman-Hollings, compensation, pension and DIC are specifically exempt from mandatory across-the-board cuts. In addition, at least 40-percent of the nondefense items in the overall budget have been exempted from Gramm-Rudman-Hollings. Thus those nonexempt areas will be forced to shoulder an extremely disproportionate share of the cuts. The massive impact of these cuts falls on the cost of operating the Department of Medicine & Surgery and Veterans Benefits, including construction needs.

The requested authority for DM&S of a little more than $9 billion represents a cut of $46.1 million from 1985 levels, including more than $134 million from hospital care. More than 7,500 professionals will be cut from DM&S, including more than 1,300 nurses and more than 500 doctors, with a projected additional cut of over 15,000 by 1991. In other words, the Grace Commission will have its way, and this budget is its blueprint.

This budget proposal means a cut of 1.1 million in outpatient visits, and about 60,000 inpatients, in the face of a current turn-away rate of about 30,000 veterans a month. We are also looking at a bed level cut of 2,700, modified by the addition of about 500 nursing home beds previously approved, and by expanding existing facilities. Overall construction will be cut some $332 million, over and above the 1986 Gramm-Rudman cuts of some $21.8 million, resulting in the cancellation of seven previously planned nursing homes.

Mr. Chairman, as we look at Medical Construction, we all agree that many VA facilities are aged and in need of replacement or modernization. Focus needs to be centered on all construction projects - present and future. How can, or will, the VA respond to a veteran population which places greater annual demands on the VA for medical care? What conclusions can be drawn when the construction account is proposed at $408 million, down $368 millions since FY 85? What will become of major and minor construction projects? How is the VA planning for the aging veterans and their related medical problems? A fresh coat of paint hides little and does little. The Replacement and Modernization account is down $188.8 million, with Nursing Home Care down an astounding $18.4 million to $4 million; even Domiciliaries is down $22.9 million with no appropriation request for FY 87.

One possible bright spot in the medical account may be the Grants for Construction of State Extended Care Facilities, proposed at $42.4 million, up $21.5 million over FY 86. Twenty Million dollars may build a lot of state veteran nursing homes which will, of course, relieve the VA of finding space for veterans in its system. We are therefore not surprised that there is a dramatic up-turn of funds in this account.

The DM&S budget seeks a massive shift of nursing home care to state and community (read private) nursing homes, even though such facilities are not available in many areas of the country. The adoption of this budget will set the entire VA medical delivery system on a rapid course to extinction, thus destroying what over 55 years of heartbreaking struggle has built into a living monument to the pride and gratitude of a free people for the sacrifices of those who shouldered arms in defense of the nation. We cannot live with this budget, or the selfish, narrow-minded, penny-pinching philosophy on which it is based.

This concludes my statement. I will be pleased to answer any questions regarding these matters.

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF
BOB MORAN, ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
VA MEDICAL FACILITY CONSTRUCTION ISSUES
APRIL 10, 1986

Mr. Chairman and Members of the Committee, I am Bob Moran, Associate Legislative Director, Paralyzed Veterans of America, and I am accompanied here today by Mr. Kim Beasley, Associate National Service Director, Paralyzed Veterans of America.

I would like to thank you and the Members of this Committee for holding this most important hearing concerning these issues that are so critical to the well-being of our members and our nation's veterans who have experienced spinal cord injury or dysfunction. It is on behalf of these veterans who have daily contact with the VA's medical facilities, located throughout the United States, that we present our views and concerns here today.

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300

The following points address the issues cited in your invitation to testify.

1. VA medical facility construction authorization requests for fiscal year 1987.

While we thank this Committee for the restoration of construction dollars to the Administration's original FY 1987 Budget Proposal, it is difficult to comment on the adequacy of the VA's construction authorization request for one simple reason: The VA currently does not have a comprehensive assessment of construction needs. The Comprehensive Study of the VA's Organization and Procedures for Construction Health Care Facilities, completed one year ago by Booz, Allen and Hamilton/RTKL Associates (BAH/RTKL) reveals the following:

a. Initial descriptions of project scope developed by VAMCs do not provide an adequate basis for undertaking program and project planning activities. (Emphasis added)
b. The current approach to prioritizing construction projects does not provide an adequate basis for resource allocation decisions. (Emphasis added)
c. There is no clearly delineated national strategy or plan for meeting the combined construction needs of 172 VAMCs.

It is apparent, based on the findings of the study, that the VA's annual Five Year Medical Facility Construction Needs Assessment is not an assessment of need but, rather, an executive summary of major construction projects requested by 172 individual medical centers through their Five Year Facility Plans. These Five Year Facility Plans, often referred to as "wish lists," are neither accurate nor are they the product of a comprehensive planning process that would ensure viability, timeliness or reasonable cost estimates.

The current transition between medical program planning and facility planning is extremely weak. The nature of the Five Year Plan, which each VAMC is asked to produce, requires gross assumptions concerning physical solutions to poorly defined problems. The VAMCs currently do not have the capability or the resources required to do comprehensive facility planning necessary to provide a sound basis for their construction programs. The absence of a logical system of well-defined activities for facility planning and project development allow excessive fiscal pressures to dominate the process.

If individual Five Year Facility Construction Plans are as fundamentally flawed as the BAH/RTKL Study indicates, then the VA's construction authorization request has little or no basis. The VA's new Prioritization Methodology simply prioritizes construction requests, not necessarily overall construction need. The BAH/RTKL Study states that with the exception of projects required to support new programs identified in MEDIPP, little useful information is available for selecting projects and for justifying those decisions. As a result, trade-offs in resource allocation among VAMCs and among different types of projects at any one VAMC are often based on highly subjective evaluations where the greatest need exists.

The susceptibility of these evaluations to factors other than need, make planning procedures inefficient and ineffective in allocating resources in the best way possible. Information that objectively identifies overall facility construction needs is of critical importance in improving construction program planning procedures.

The VA's new Prioritization Methodology was developed in response to the directive contained in Senate Report No. 98-506, which accompanied Public Law 98-371. If the intent of this directive was to structure a priority order whereby projects that will correct the most serious deficiencies will be developed first, then we contend that the new Prioritization Methodology fails to fulfill that intent becuase no mechanism currently exists whereby the relative comparison can be established. Furthermore, Public Law 96-222, Section 5007, requires that the VA, each year, submit a listing, in priority order, of the medical centers it finds are most in need of construction, replacement or major modernization. In response to this Public Law, the VA developed its first Five Year Medical Facility Construction Plan in August 1979. Now that the BAH/RTKL study has identified the inadequacies of this planning methodology, this Public Law is, in fact, unfulfilled.

The FY 1986 - FY 1990 Five year Medical Facility Construction Needs Assessment does not represent an overview of the need for facility improvements to support the health care mission of the VA.

PVA recognizes that these are strong criticisms regarding the VA's current planning, design and construction program. Nevertheless, in light of current budgetary pressures to adopt efficient operational practices, the BAH/RTKL Study, upon which these criticisms are based, is timely. The VA needs to address these serious inadequacies so that the expenditure of scarce resources can efficiently and effectively correct construction needs where they are most acute.

It is important to note that the former Administrator of Veterans' Affairs, Harry Walters, acknowledged in a letter to the Executive Director of PVA, November 1, 1985, that he agreed with the findings of the BAH/RTKL report, both in terms of procedures and organization. This brings us to the second issue which is the proposed reorganization of the VA's construction planning process and organizational structure.

2. Proposal for the reorganization of VA's construction planning process and organizational structure.

In the November 1, 1985, letter to the Executive Director of PVA, referenced earlier in this testimony, former Administrator Harry Walters indicated that it would be advantageous to designate, concurrently, "a single point of accountability for the agency's construction program." He went on to say that discussions with BAH/RTKL principals, veteran service organizations and Congressional staff "have confirmed that a major organizational realignment is a prerequisite to an improved agency construction program." PVA agrees with that position.

Nevertheless, the proposed reorganization currently being considered fails to acknowledge the impact of the procedural changes necessary to improve the construction program. It is important to note that the BAH/RTKL Study recommendations are two part: 1) Process Recommendations and, 2) Organizational Recommendations. It is not coincidental that Core Process

Recommendations precede Organizational Recommendations. There is an inherent danger in implementing a detailed reorganization plan around a seriously flawed process.

The Core Process Recommendations which correct the serious procedural flaws should, in fact, be the basis of the proposed reorganization. PVA has requested a meeting with Chief Medical Director to discuss the Core Process Recommendations and their impact on the appropriate organizational structure needed to ensure quality, timely and cost effective medical facilities for our nation's veterans. The emphasis on process changes is consistent with Mr. Walter's November 1, 1985, letter in which he states, "I have made the decision to implement the procedural recommendations as the best means to make major improvements in the timely and efficient delivery of health care construction."

It is clear that reorganization alone will not correct the problems cited. One painful example of the current system's inability to perform effectively is evidenced in the VA's proposed Nursing Home Care Prototype. This notable initiative, which began in April 1983, sought to provide a prototypical building design resulting in quality, timely, cost effective facilities to meet the long term needs of our aging veterans. PVA believes that this initiative was significant, viable and necessary in view of this nation's economic climate and scarce resources. However, three years later, the VA Inspector General, in a report dated January 3, 1986, states that, "The VA has not yet accomplished its major program initiative of developing a nursing home care unit prototype that provides quality, timely and cost effective facilities to meet the long term needs of aging veterans."

The report's conclusion stated that, in the opinion of DM&S and O/C representatives, "The planned reorganization of O/C and DM&S will correct organizational issues leading to problems surfaced in this review." The Inspector General, however, stated that, "In our opinion, the planned reorganization of O/C and DM&S will *not* ensure resolution of the issues related to the NHCU prototype." The Inspector General's recommendation was this, "The VA should establish an appropriate design and approval *process* for assuring a cost effective design of prototype nursing homes." (Emphasis added)

It is our concern that too much emphasis is being placed on organizational structure and not enough emphasis given to crucial *process* changes.

The seven process recommendations presented in the BAH/RTKL Study represent a comprehensive approach to improving current policies and procedures in the health care facility construction process. The first recommendation begins by addressing individual medical facility needs in a systematic way, using common tools and data bases which yield comparative analyses necessary for effective resource allocation. The recommendations that follow build upon one another and strengthen the total process.

It is imperative, therefore, that the proper implementation of these Core Process Recommendations be assured. Given the interrelated nature of these recommendations, failing to properly implement the first one will have a cumulative affect on the remaining six. It is our understanding that the VA has targeted five million dollars per year, for the development of Facility Development Plans (FDP) which is, in fact, the first Core Process

Recommendation. The BAH/RTKL Study indicates that the development of FDP/s would require some preliminary work. Specifically, this initiative would require the development of:

1. FDP guidelines to ensure consistency.
2. Computer system data requirements and programs.

To avoid costly errors in the development of this significant initiative, it is imperative that this preliminary work be completed. Our concern is that the preliminary work may not have been done. In recent VA testimony before the House Committee on Veterans' Affairs, Subcommittee on Hospitals and Health Care, March 6, 1986, VA officials indicated that the nearly completed Capital Facility Studies (CFS) compliment and feed into the FDPs. An analysis of the CFSs and the BAH/RTKL recommendation for a planning data base will show that the CFSs do not fulfill the requirements of the recommended planning data base. The successful implementation of this recommendation is crucial because of its use for resource allocation and decision modeling on national, regional, district and local levels.

Core Process Recommendation number four also elaborates on the data base used at the national level. Data on existing facility characteristics and required facility characteristics could provide aggregate information needed for determining overall system needs. The comparative nature of the described data base would provide a basis for broad resource allocation decisions among regions, districts or VAMCs.

Another key process recommendation focuses on the need to improve process level standards and control tools. National standards and criteria affect the planning, design cost and operation of every medical facility construction project each year. Yet, according to the BAH/RTKL Study, minimal manpower and effort is currently expended to maintain, test and update these standards. The study indicates that the "implementation of this recommendation would require a great deal of effort not currently expended on standards development activities." The recommendation would signficantly impact an existing organizational structure, requiring radical changes in the development of standards and manpower needed to perform the tasks.

3. Integration of the Medical District Initiated Program Planning (MEDIPP) and construction planning processes, including long-term strategic planning, proposed medical facility mission changes and consideration of purchasing or leasing already existing private sector facilities.

This issue is specifically addressed in the BAH/RTKL Study which states there is currently a very weak relationship between MEDIPP and construction planning. The planning data base recommended in the study establishes a direct correlation between MEDIPP and construction planning. Since the MEDIPP program was not addressed in the BAH/RTKL Study, specific weaknesses were not identified. PVA supports the concept of medical program planning initiated at the district level. The implementation of BAH/RTKL recommendations should strengthen this program.

The VA's Facility Strategic Planning effort is an attempt to deal with the problem of unsystematic and poorly coordinated Five Year Facility

Construction Plans. This effort, however, is hampered by the lack of appropriate planning tools, information and manpower. The Core Process Recommendations, properly implemented, should fulfill the intent of the current strategic planning effort.

Proposed facility mission changes and consideration of purchasing or leasing already existing private sector facilities represent major decisions with far reaching implications. Once again, the VA should be in a better position to measure the impact of these types of major decisions if a needs assessment of the total system can be determined.

4. Delegation of VA construction projects to VA medical centers directors, including advantages and disadvantages of delegation, current status of delegation efforts, and future plans for delegation.

It is easy to empathize with VAMCs who, over the course of recent years, have become dissatisfied with a construction planning system that grew less and less responsive to their needs. The process is lengthy, cumbersome and inefficient in providing capital improvements to their physical plants. They are often left out of key areas of project development.

It is unfortunate that delegation is seen by some as a solution to these problems. It should be noted that the idea of delegation is in direct conflict with the BAH/RTKL recommendations. In contrast, the BAH/RTKL Study includes a comprehensive analysis of the current system and clearly defines procedural and organizational problems (see phase II of the Study). Phase II of the study became the basis for recommending a comprehensive solution to the planning, design and construction problems. The BAH/RTKL Study recognizes the proper role of VACO in all aspects of the process.

Another key role for VACO is that of a "clearing house" of valuable data and information critical to maintaining standards and criteria used in a large system of individual medical facilities. Recognizing that the VA's standards, criteria and data bases are in need of considerable improvement, which contributes to the erosion of confidence by VAMCs in VACO, the BAH/RTKL Study recommends fundamental improvements in process level standards and control tools. The tragedy of delegation lies in its lack of feedback mechanisms and control tools that are critical to maintaining agency standards, criteria and data bases. Implicit in this important recommendation is a VACO mindset that needs to change from an indifferent, passive, dictatorial view of enforcing standards, to an attitude more reflective of public servants who have a responsibility to 172 medical centers, not to mention veterans, to assess their needs and ensure that current state of the art medical practices are accommodated in VA standards and criteria.

Another disadvantage to delegation is that the average VAMC sees very few major construction projects and, therefore, is not adequately equipped to deal with the contractural problems and lengthy design processes.

5. Options for providing parking at VA medical facilities.

While it is apparent the Administration, and possibly this Committee, is examining the issue of funding for beneficiary travel as one area of a major budget reduction, the whole issue of travel goes hand-in-hand with totally accessible VA facilities. A reduction in the beneficiary travel account ranging from over 90 percent to not quite 50 percent would leave funding for only medically-indicated travel by special modes of transportation.

The reduction in funding when coupled with inadequate parking facilities, places a significant hardship on many veterans, both service-connected and non-service-connected who rely on this benefit to get to and park at VA facilities. It is also important to remember that this particular group of veterans is composed of disabled veterans, with some not being able to ambulate and requiring designated handicapped parking spaces. It must also be remembered that many cities do not have accessible public mass transportation systems.

It is these veterans, who have special parking requirements such as wheelchair parking, with most being the more catastrophic disabled who will be hit the hardest by a reduction of travel allowances and inadequate parking.

6. Impact of Gramm-Rudman-Hollings fiscal year 1986 sequester order on construction projects and projected impact of a fiscal year 1987 sequester order.

In reference to the impact of Gramm-Rudman-Hollings on the Fiscal Year 1986 Construction Projects, it is our understanding that each major construction project will absorb a proportional share of the reduction, and efforts will be made to complete projects at a reduced level. Consequently, a 4.3 percent reduction, or for that matter almost any reduction is nullified by A/E Design change fees and most likely change orders in the fields. This is particularly true and has a significiant impact on construction projects that are in the late stages of design or working drawings, not to mention those already under construction.

7. VA Department of Defense sharing of medical care resources such as the proposed joint VA-Air Force Sharing agreement in Albuquerque, New Mexico.

And lastly, Mr. Chairman, PVA would like to comment on the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, P.L. 97-174, mandating the VA to serve as the primary health care back up to the Department of Defense (DOD) in the event of war or national emergency.

As you are aware, Mr. Chairman, the VA and the U.S. Air Force, in keeping with Public Law 97-174, have entered into a pilot project to reduce costs, maximize utilization of resources and promote quality care. Prior to the agreement, the Air Force had planned a major addition to the Air Force hospital at Kirtland Air Force Base in 1987.

The Veterans Administration and the U.S. Air Force have agreed to joint use of the new VA Medical Center Albuquerque, New Mexico scheduled to open in late 1986. Under the agreement a portion of one floor, approximately 40 beds, will be dedicated to Air Force use and will be staffed by Air Force personnel.

This is not the first time that the VA and the Air Force have worked together to provide medical services. Although the VA and the Air Force are currently involved in 41 sharing arrangements throughout the country, this project is the first significant sharing by the VA of its inpatient resources and programs with a DOD facility.

Both those who use the VA medical system and those who use military hospitals will benefit from this joint venture since the sharing arrangement will offer a wider variety of specialty services not usually found in either an Air Force or VA medical center alone.

Mr. Chairman this concludes PVA's written testimony for the record, and again, PVA appreciates the opportunity to testify here before you today. We thank you and members of the Committee for your thoughtful consideration of these most important issues, and I would be happy to respond to any questions you might have.

PVA

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

APR 22 REC'D

April 18, 1986

The Honorable Alan Cranston
Ranking Minority Member
Senate Committee on Veterans' Affairs
SD-414 Senate Dirksen Office Building
Washington, D. C. 20510

Dear Senator Cranston:

Paralyzed Veterans of America appreciated very much the opportunity to testify at the April 10, 1986, Senate Committee on Veterans' Affairs hearing, concerning VA construction issues, and we have enclosed information concerning the Nursing Home Care Unit prototype, in which you expressed an interest during the hearing.

Enclosed is a letter, dated November 25, 1985, to the VA Administrator, Mr. Harry Walters, from Victor S. McCoy, Sr., PVA's National Service Director, concerning the VA's Nursing Home Care Unit prototype, and various attachments listing: PVA's involvement in the VA's NHCU prototype; specific design problems; overlay analysis; and questions. Also included is an I.G. report dated January 3, 1986, concerning the development of the NHCU prototype.

We appreciate your interest in this particular matter and feel this information will be of great interest to you. We would like it to be submitted for the hearing record.

Again, thank you for the opportunity to appear before you on April 10, and as always, we look forward to working with you in the future.

Sincerely yours,

Bob Moran

Bob Moran
Associate Legislative Director

BM/dac

Enclosures

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300

PVA

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

November 25, 1985

Mr. Harry N. Walters
Administrator (00)
Veterans Administration Central Office
810 Vermont Avenue, N.W.
Room 1000S
Washington, D.C. 20420

Dear Mr. Administrator:

During your tenure as the Administrator of Veterans' Affairs, the VA has made great strides in fulfilling its mandate to care for the veteran. It has been a great privilege for PVA to work with you in your efforts to carry out the objectives spelled out in your Missions and Goals Statement. The PVA appreciates the professional relationship you have established with veterans' organizations and, in particular, the opportunity to participate in the VA's facility planning, design and construction process.

One of your many notable initiatives was to develop a nursing home care unit prototype that provides quality, timely and cost effective facilities to meet the long term needs of our aging veterans. The development of this initiative was well publicized, claiming that construction time schedules would be reduced and significant cost savings realized without compromising quality of care.

The PVA believes that this initiative was significant, viable and necessary in view of this nation's economic climate and scarce resources. However, since the PVA's involvement in this NHCU prototype effort, a series of events, which have prompted this letter, have left us totally frustrated and disbelieving.

The drawings received to date lack the coordination and clarity that would assure the Paralyzed Veterans of America that the aging veteran will be well served in the proposed prototype design. The prototype NHCU design, dated 9/25/85, is lacking in quality and substance from its most basic overall design concept to the minute detail. Our detailed analysis is contained in the attachments. Please note the following major concerns:

1. The prototype design does not comply with the Uniform Federal

Accessibility Standards (UFAS), dated 8/7/84, which state that "these standards are to be applied during the design, construction, and alteration of buildings...to the extent required by the Architectural Barriers Act of 1968" (PL 90-480). The three nursing home care units under construction and eleven in the working drawing stage are not in compliance with federal law.

2. The prototype design demonstrates minimum flexibility and maximum site coverage. This expansive configuration creates unreasonable travel distances for patients and staff which will adversely impact on the quality of life and care for the veteran. The cruciform nursing unit, while satisfactory from a nurse station viewpoint, creates odd room configurations, poor accessibility and areas of congestion.

3. The prototype design does not comply with VA standards regarding minimum requirements for design submissions. These standards require that during preliminary design, basic structural and mechanical systems be shown, alternative systems investigated and building sections drawn to show critical clearances. Our analysis verifies that conventional structural and mechanical systems, when overlayed on the prototype, render many spaces inaccessible and unusable. (see attachment "C")

These design flaws and violations of standards are now and have been known to responsible people in the Office of Construction. However, rather than taking corrective actions, it appears to us that attempts have been made to mislead PVA into accepting the defective product and, even more outrageously, that possibly attempts have been made to mislead and misinform you in order to obtain your approval of actions which have had, and will continue to have, a serious impact on the credibility of the Veterans Administration, those who manage its resources, and most importantly, the quality of care for veterans.

Our frustration has not been limited to the prototype. Most recently, our review of the proposed SCIU for VAMC Dallas indicated a radical departure from the successful design approaches used for San Diego, Salt Lake City and Long Beach. The design of the Houston replacement hospital has resulted in a proposed SCIU that doubles staff, compromises rehabilitation functions and inhibits proper patient supervision. The PVA's insistence on proper facility design resulted in the redesign of the SCIU at VAMC San Diego.

In view of the events that have brought me to this level of frustration and my strong conviction of the merits of your initiative, we requested of the ADA for Logistics, in June 1984, that the architect responsible for the successful design of several spinal cord injury units (SCIU), document his design methodology to aid in future design efforts. This methodology uses prototypical design components interchangeably to satisfy various programmatic needs. The actual design process is preceded by "Design Programming," a task which simply involves the gathering of appropriate information needed to make proper design decisions. The PVA believes that the attached documentation of the successful use of prototype buildings and component parts for SCIUs demonstrates the validity of your initiative to use prototype design concepts.

In summary, Harry, the evidence seems to be overwhelming that no suitable prototype nursing home plans actually exist, that costly errors in planning, design and construction have been made to date; that obfuscation, denial, and outright fabrication have been utilized by certain people in the Office of Construction to conceal these errors, bad judgement, and lack of professional competence.

We understand that these are serious allegations, but we are convinced that the evidence is more than sufficient to require this action from PVA as a responsible veterans' organization. We also feel compelled to bring to light these problems in the best interest of the Veterans Administration and of our friends and colleagues there who are honest, ethical, and highly competent, but whose reputations may be tarnished by the irresponsible actions of the few whose standards of conduct and performance are not acceptable to PVA or the Administration.

It has been our pleasure to work with you personally and professionally on a basis of mutual respect and this statement is submitted to you in that spirit, with full confidence that the issues which we have raised will be promptly and seriously considered and resolved.

Sincerely,

Victor S. McCoy, Sr.
National Service Director

VSM:mmm

cc: R. Jack Powell, Executive Director

ATTACHMENT "A"

Chronological Events of PVA Involvement in V.A. NHCU Prototype

* PVA expresses concern for accommodation of the long term care spinal cord injury (SCI) patient in the proposed nursing home care unit (NHCU) prototype.

* Administrator approves the addition of two large bedrooms per 60 bed unit on the NHCU prototype to accommodate SCI patients.

* PVA request VACO for a complete set of the NHCU prototype design.

* Administrator indicates that there will be no (00) approval of prototype until PVA reviews the entire design.

* Two months after initial request for the prototype, PVA again calls VACO for drawings of prototype.

* 6/13/85
  VACO requests to give PVA a briefing - PVA rejects offer, repeats request to see complete set of drawings before briefing.

* 7/1/85
  PVA given 8½"x11" illegible Xerox of prototype sketches. PVA rejects, request full size.

* 7/2/85
  Allen Mauer contacts Deputy National Service Director and informs him that DM&S has a problem with the prototype and was redesigning before presenting to PVA.

* 7/3/85
  DM&S call - cancels presentation.

* 7/85
  PVA reviews prototype "sketches" and determines that all bedrooms and most bathrooms are inaccessible to the handicapped (wheelchair) patient.

* 7/85
  PVA informs Susan Livingston of violations concerning UFAS accessibility standards.

* 9/85
  Office of Construction redesigns bedrooms to comply with some of the accessibility standards.

- * 9/20/85
  Full size set of revised plans received by PVA (3 months after initial request) set is incomplete. Enlarged plans of core facility are missing.

- * 9/27/85
  PVA Contacts DM&S asks for detailed core design as well as preliminary structural and mechanical drawings.

- * 9/27/85
  Mr. Spatz, Assoc. Director Office of Construction informs Deputy National Service Director that it would be impossible to give PVA the structural and mechanical drawings since that information isn't available until working drawings.

- * 9/27/85
  PVA obtains completed preliminary design of Prescott, Arizona prototype NHCU from the Office of Construction which contain structural and mechanical drawings.

- * 9/27/85
  PVA contacts Susan Livingston, cancels V.A. briefing.

ATTACHMENT "B"

Examples of Specific Design Problems

1. Non patient care spaces are located adjacent to the nurse station while patient rooms with the greatest need for nurse supervision and assistance (long term SCI) are located the farthest from the nursing staff and support areas.

2. Travel distances for patient and staff are excessive:
   60 ft. from nurse station to nearest bedroom
   165 ft. to nearest (SCI) large bedroom
   220 ft. from (SCI) large bedroom to dining room.

3. Patient bedroom doors are not wheelchair accessible. The UFAS standards regarding door maneuverability (4.13.6 fig. 25) require a minimum of 18" clear on the latch side of the door. The only exemption applies to acute hospital patient rooms.

   NOTE:
   This problem was corrected in September 1985 as a result of a PVA request to the Assoc. Deputy Administrator for Logistics.

4. Patient toilets in the nursing unit do not accommodate a side transfer with appropriate grab bars as required by the Uniform Federal Accessibility Standards (UFAS).

5. Patient bedroom vanities do not conform to V.A. standards. V.A. standard detail 53 D establishes 3'-0" for a vanity width. (2'-6" is generally regarded as an absolute minimum.) Most vanities shown are 2'-0" wide.

6. Detailed plans of the prototype do not indicate structural or mechanical systems which usually impact interior spaces. Our overlay studies (see attached sketches) of conventional structural/mechanical systems as shown on the preliminary design of the prototype NHCU at Prescott, Arizona, indicate that:

   a. Columns fall within wheelchair turning radius, vanities, doorways, furniture and plumbing chases.

   b. Perimeter heating systems, such as fan coil units, intrude on bedroom space and create accessibility problems.

   NOTE:
   The Office of Construction insists that a "radiant panel system" will be used. Was a comparative life cycle cost analysis performed on alternative systems as required by Executive order 12003? Originally, the prototype was to consider alternative systems as part of its "flexibility."

7. Entrances from courtyards to patient lounges are not accessible to the wheelchair patient.

8. Most patients cannot be observed by staff from bedroom doorways, necessitating staff entry into bedrooms for visual checking.

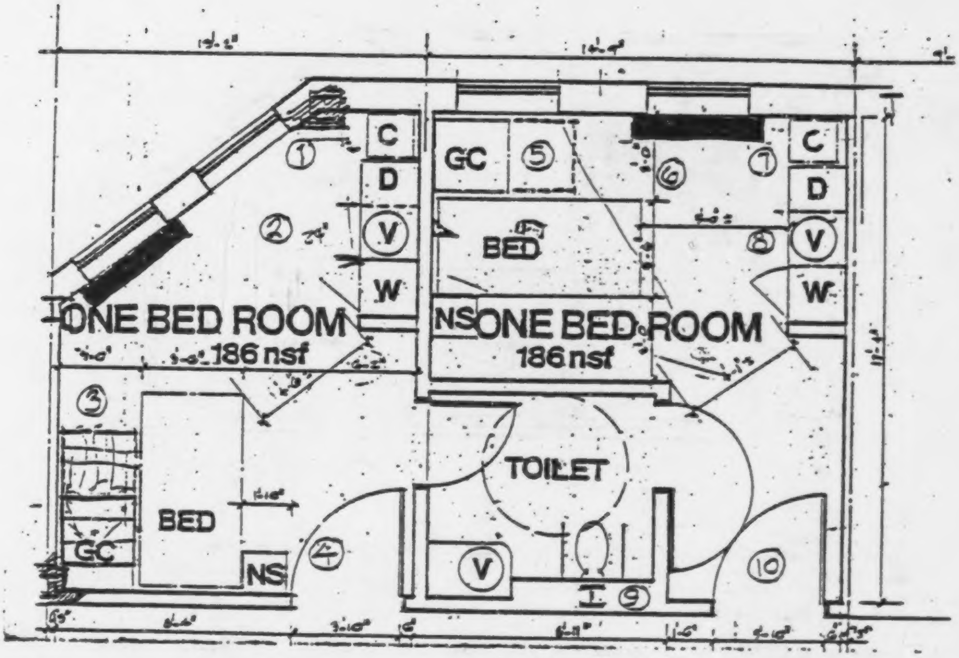
9. Beds shown are 7'-0" long. Typical patient beds are normally in the 7'-6" - 7'-10" range. How can we ensure that each medical center can procure this odd sized bed? The use of a more typical and common bed size (Hill Rom) would restrict door openings in many bedrooms.

10. Drawings do not indicate whether geriatric chairs recline. Reclining geriatric chairs become elongated in both directions which conflict with walls, furniture and critical clearances.

11. Symbols such as G, NS,D,W,V depicted on the drawings are unexplained.

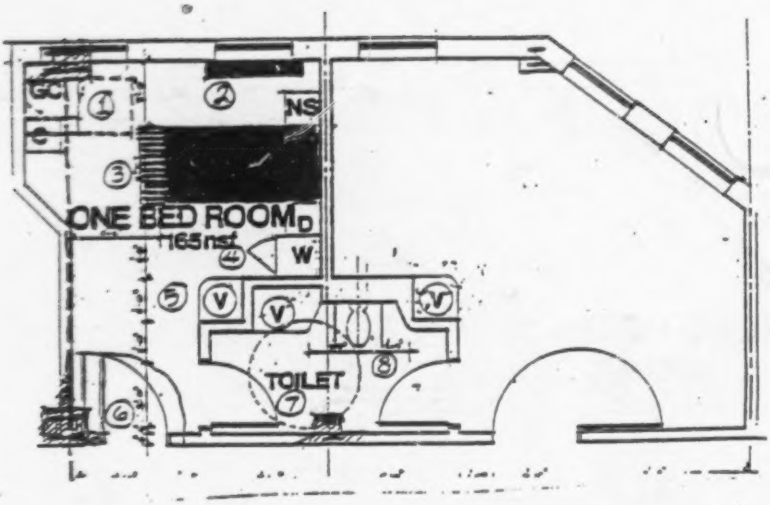
ATTACHMENT "C"

Overlay Analysis



ONE BED ROOM
186 nsf
ONE BED ROOM
186 nsf
TOILET
BED
BED
GC
GC
NS
NS
C
D
V
W
C
D
V
W
V
24"
①
②
③
④
⑤
⑥
⑦
⑧
⑨
⑩

1. Column interferes with furniture arrangement.
2. 24" vanity is less than VA standard of 36"
3. Geriatric chair fully extended is awkward, compounded by column interference.
4. Door is not accessible to wheelchair patient because of furniture arrangement.
5. (See #3)
6. Fan coil unit at window (ref. Prescott prototype NHCU prelim. design) restricts access around bed.
7. Fan coil unit interferes with furniture access.
8. (See #2)
9. Column interferes with toilet plumbing.
10. Nurse cannot see patient from bedroom doorway.



1. Double columns interfere with Geriatric chair. Chair extended creates accessibility problems.

2. Fan coil unit reduces clearance to about 2'-0"

3. Non-standard 7'-0" bed is shown. A more realistic length is 7'-9" which creates clearance problems.

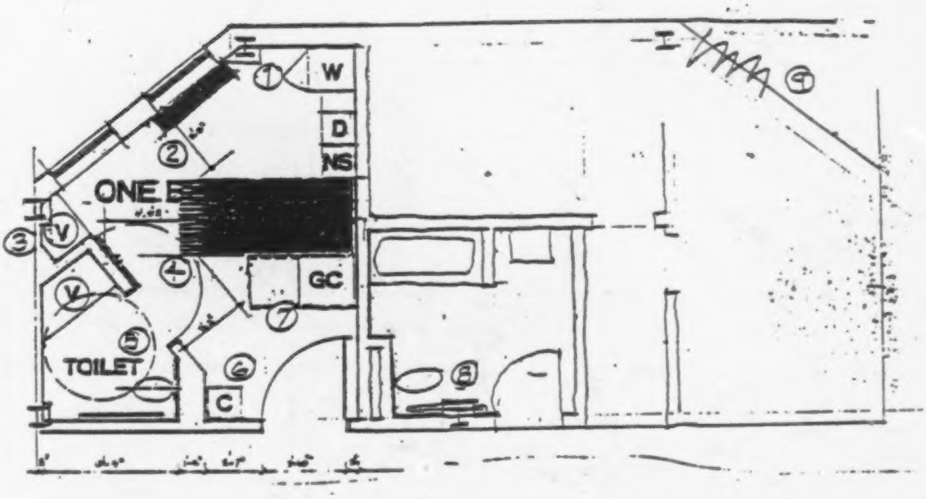
4. Wardrobe cabinet is difficult to access by wheelchair patient.

5. Vanity is approximately 24" square. VA standard is 36"x24"

6. Columns interfere with doorway.

7. Column interferes with turning radius.

8. No side transfer capability.



1. Column interferes with access to wardrobe locker.

2. Fan coil unit reduces clearance between bed.

3. Vanity as shown is not accessible to wheelchair patient. Column location renders vanity useless.

4. Doorswing will interfere with a standard 7'-9" bed.

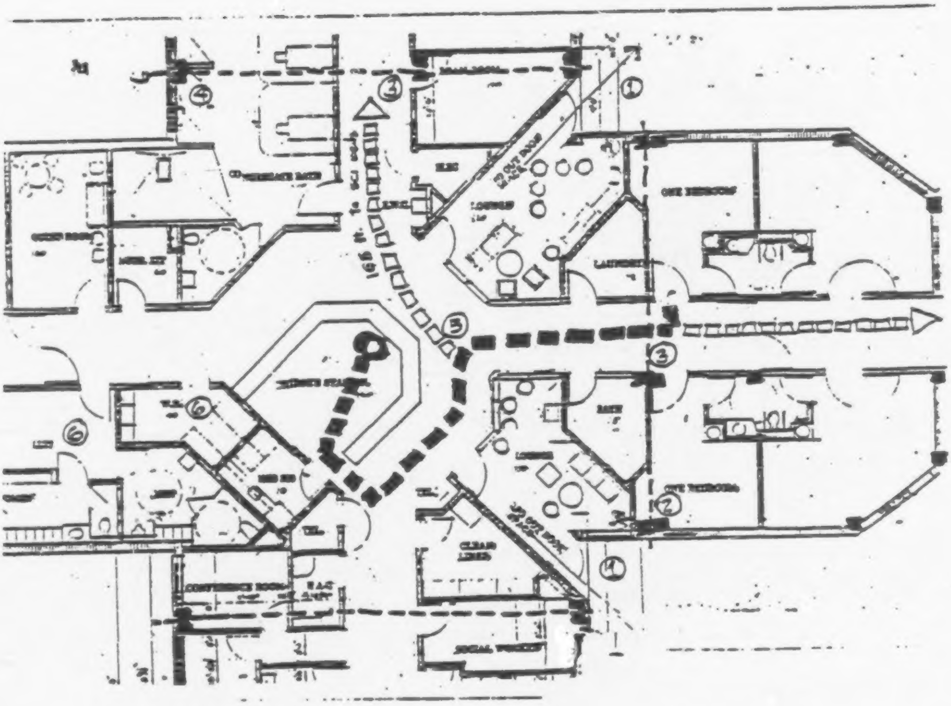
5. No side transfer capability.

6. Furniture location makes door inaccessible to the wheelchair patient.

7. Geriatric chair fully extended restricts access to bed.

8. Column location interferes with grab bar and toilet.

9. Drawing shown incorrectly.


①
②
③
③
④
④
⑤
⑥
⑥
165 ft. to SCI bedroom
ELEC
LOUNGE
LAUNDRY
ONE BEDROOM
ONE BEDROOM
NURSE STATION
W.R.
BATH
LOUNGE
TEL.
TEL.
CLEAN LINEN
CONFERENCE ROOM
SOCIAL WORKER

1. Courtyard entrance not accessible to wheelchairs
2. Double columns at seismic joint interfere with window and furniture.
3. Double columns at seismic joint located in doorway.
4. Double columns at seismic joint interfere with shower clearance.
5. Excessive travel distance to first bedroom from nurse station. 165 feet to SCI bedroom.
6. Non-critical functions (storage, employee lockers, lounge, toilets) located adjacent to nurse station.

ATTACHMENT "D"

Questions

1. Why was the cruciform configuration used? Were others studied? What were the results of the study?

2. Why are patients with the greatest need for supervision located the farthest from the nursing staff and support areas?

3. Why are non-patient care spaces located immediately adjacent to the nurse station? (i.e., staff lockers, lounge, toilets and storage)

4. What will be the long term impact of such a site consuming design on the future growth capabilities of medical centers receiving the prototype?

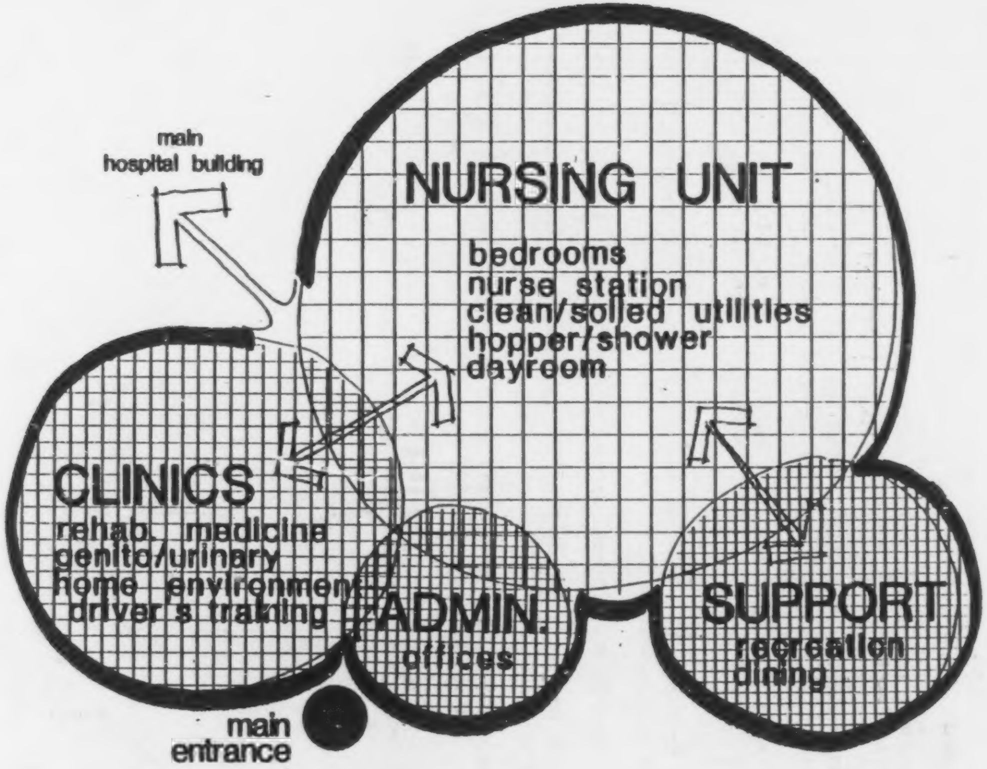
5. How is the prototype flexible and adaptable to specific geographic, seismic and site conditions?

6. Why weren't the Uniform Federal Accessibility Standards used?

7. What research was conducted by the V.A. that would support a waiver to the UFAS standards?

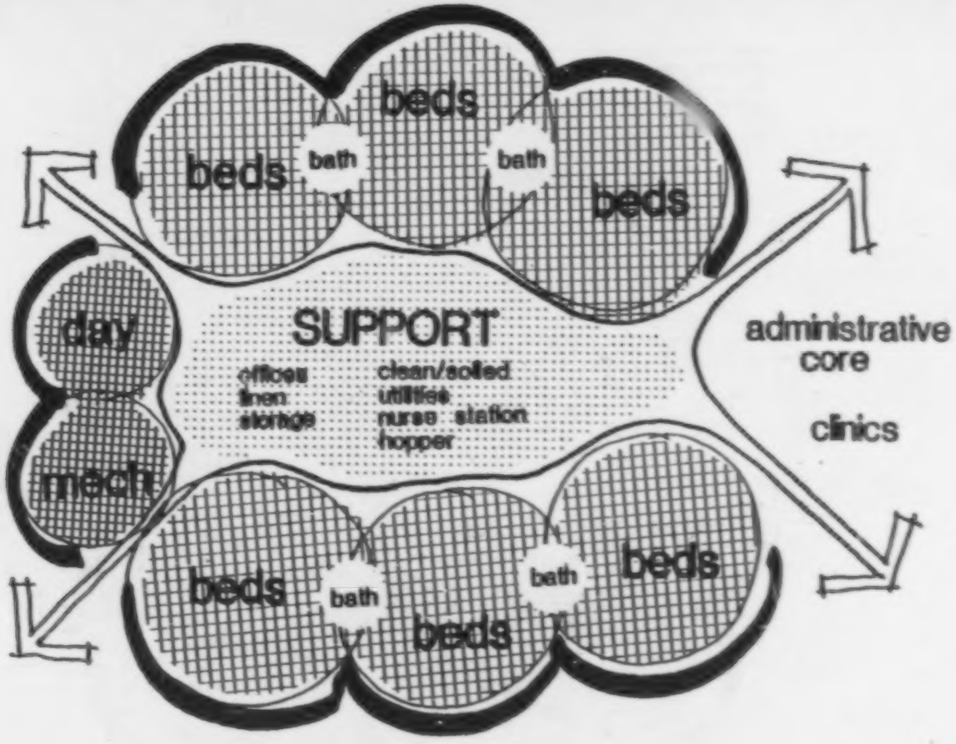
8. Why was there an attempt to gain the Administrator's approval, in spite of known violations to accessibility standards?

9. Why have variations of the unapproved prototype design been distributed for design development, working drawings and construction?


main
hospital building
NURSING UNIT
bedrooms
nurse station
clean/soiled utilities
hopper/shower
dayroom
CLINICS
rehab. medicine
genito/urinary
home environment
driver's training
ADMIN.
offices
SUPPORT
recreation
dining
main
entrance

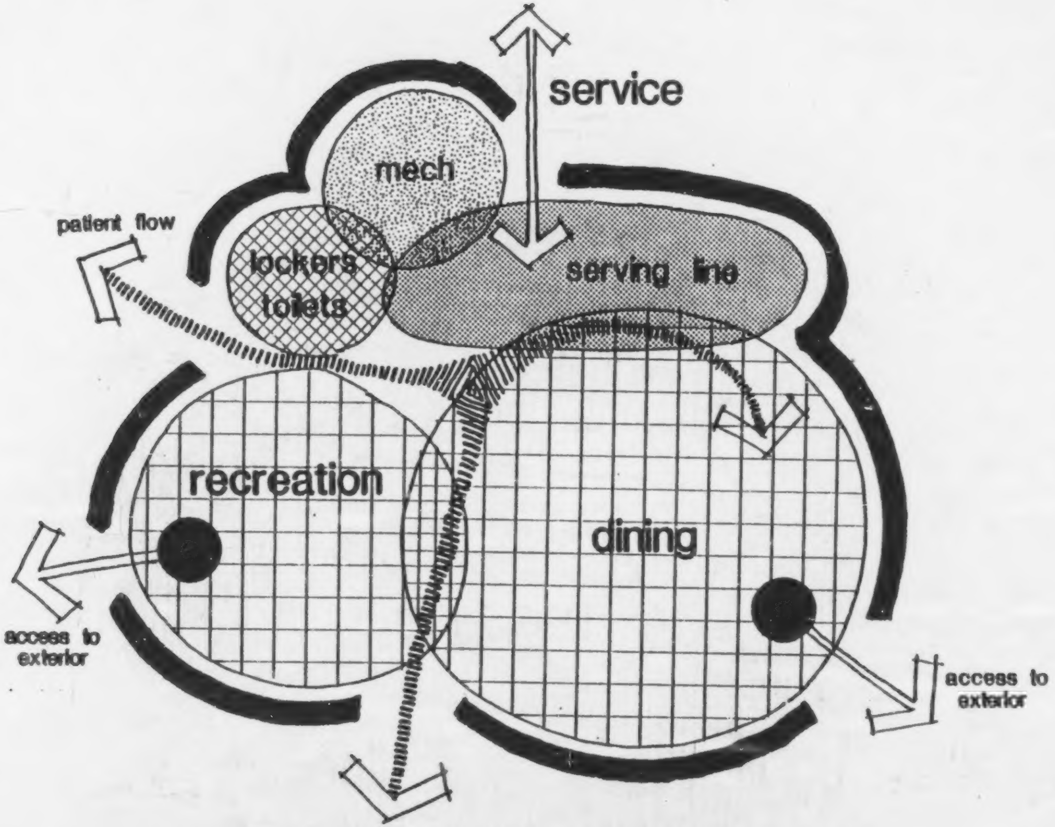
SPINAL CORD INJURY UNIT

major functional groupings


beds
bath
beds
bath
beds
day
SUPPORT
offices
linen
storage
clean/soiled
utilities
nurse station
hopper
administrative core
clinics
mech
beds
bath
bath
beds
beds

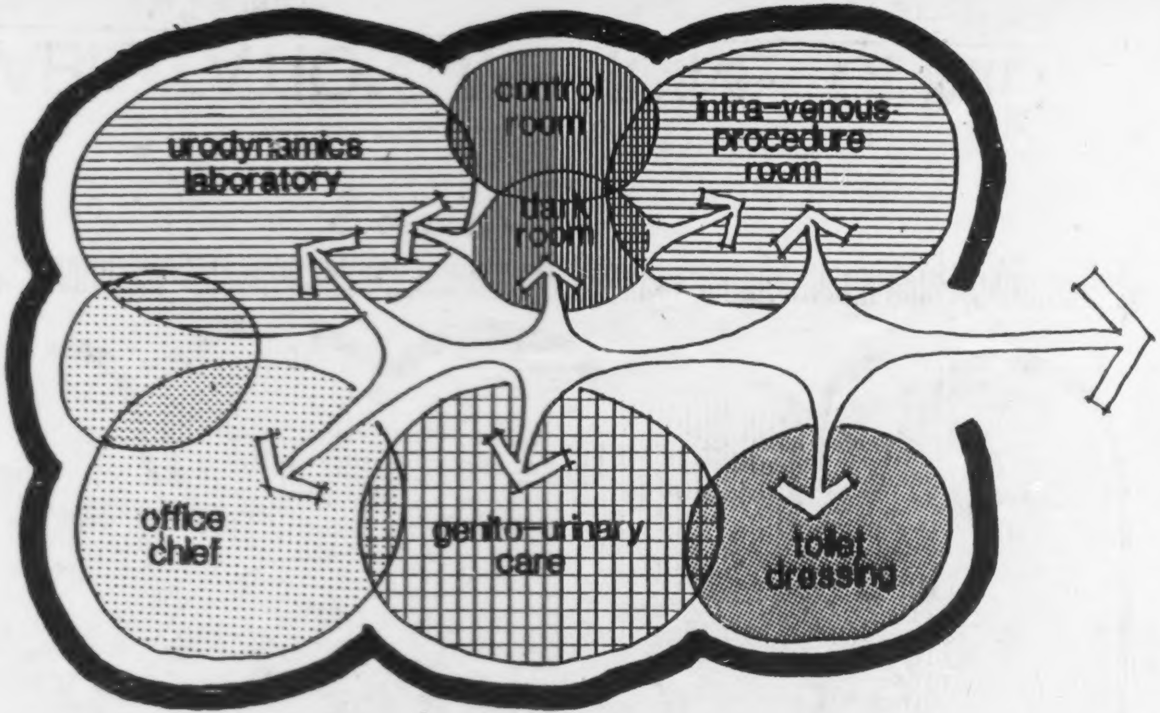
SCI NURSING UNIT

diagrammatic relationship


service
mech
patient flow
lockers
toilets
serving line
recreation
dining
access to exterior
access to exterior

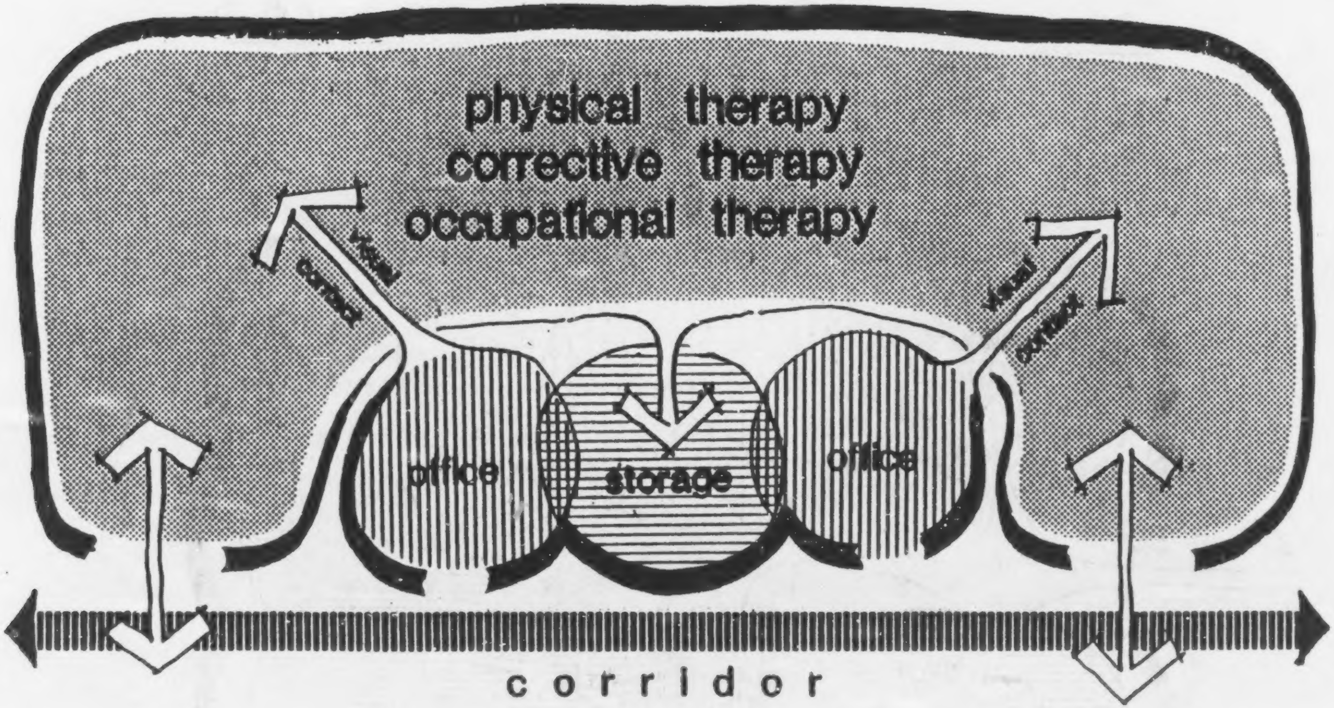
SCIU SUPPORT SERVICES

diagrammatic relationships


control room
intra-venous procedure room
urodynamics laboratory
dark room
office chief
genito-urinary care
toilet dressing

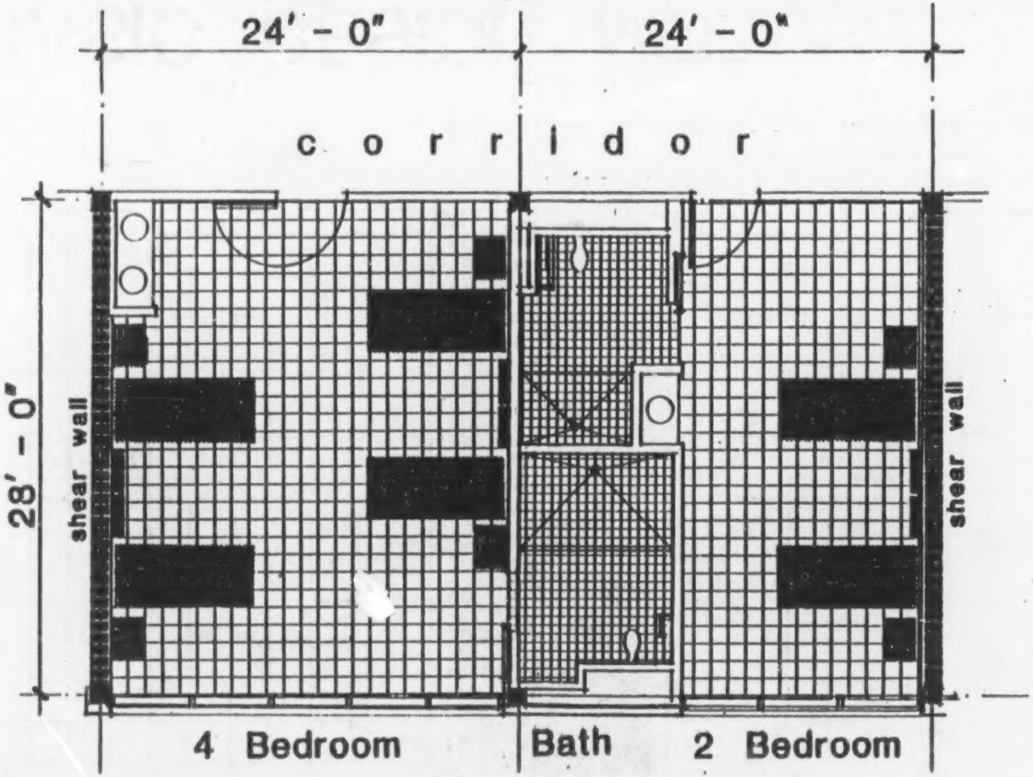
GENITO-URINARY CLINIC

diagrammatic relationships

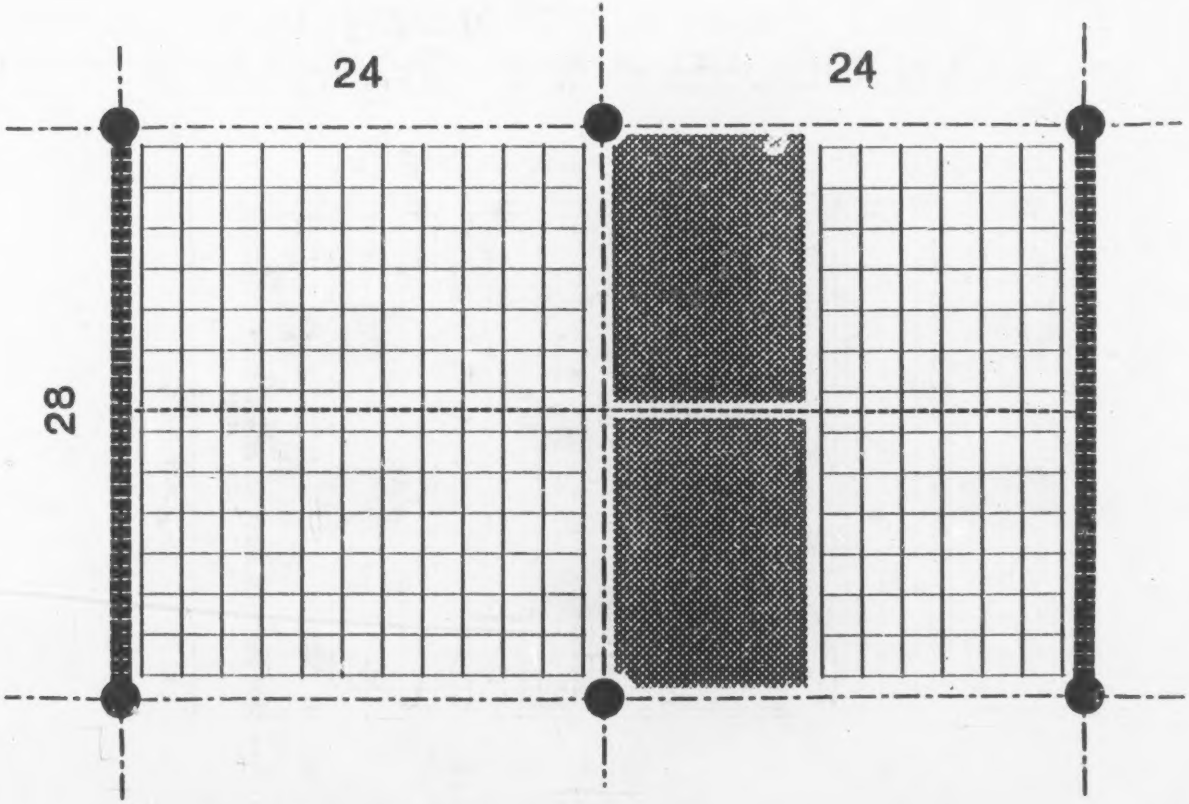

physical therapy
corrective therapy
occupational therapy
visual contact
visual contact
office
storage
office
corridor

REHABILITATION MEDICINE CLINIC

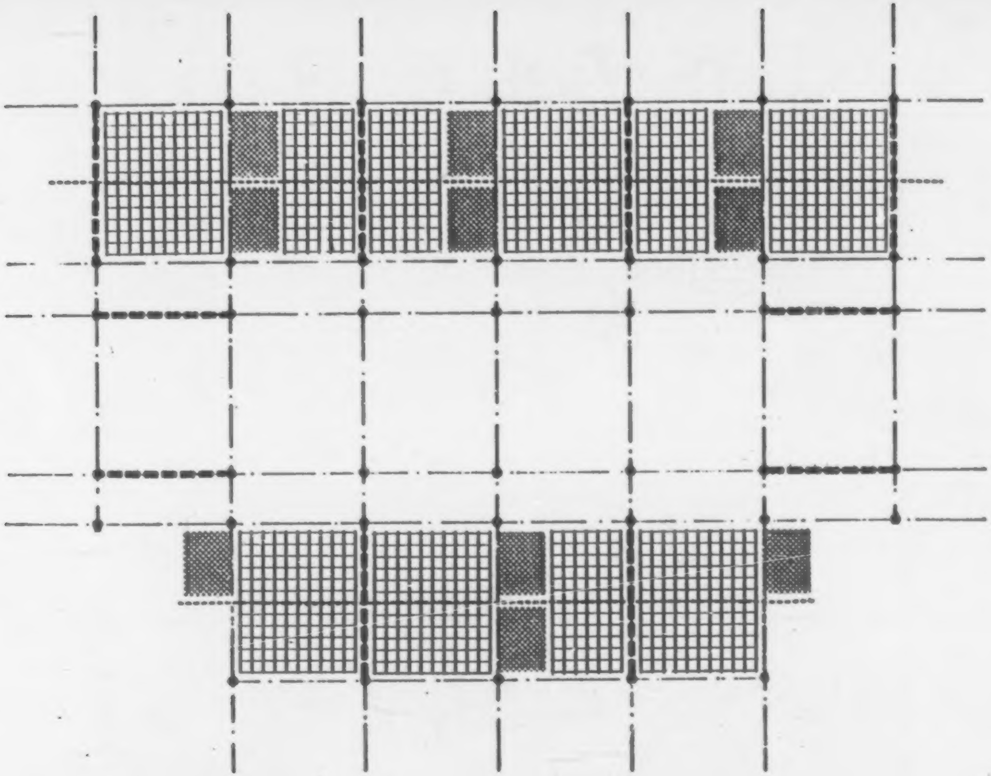
diagrammatic relationships


24' - 0"
24' - 0"
corridor
28' - 0"
shear wall
shear wall
4 Bedroom
Bath
2 Bedroom

TYPICAL 4 & 2 BEDROOMS
with Private Bathrooms

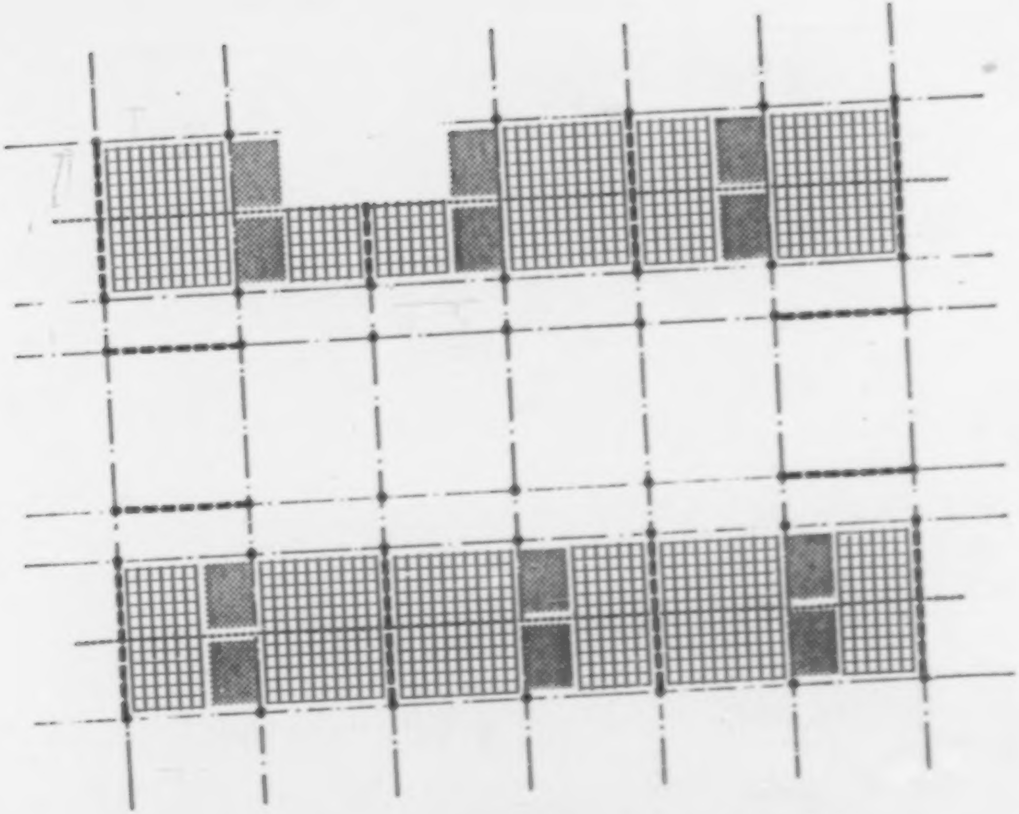


BASIC DESIGN MODULE



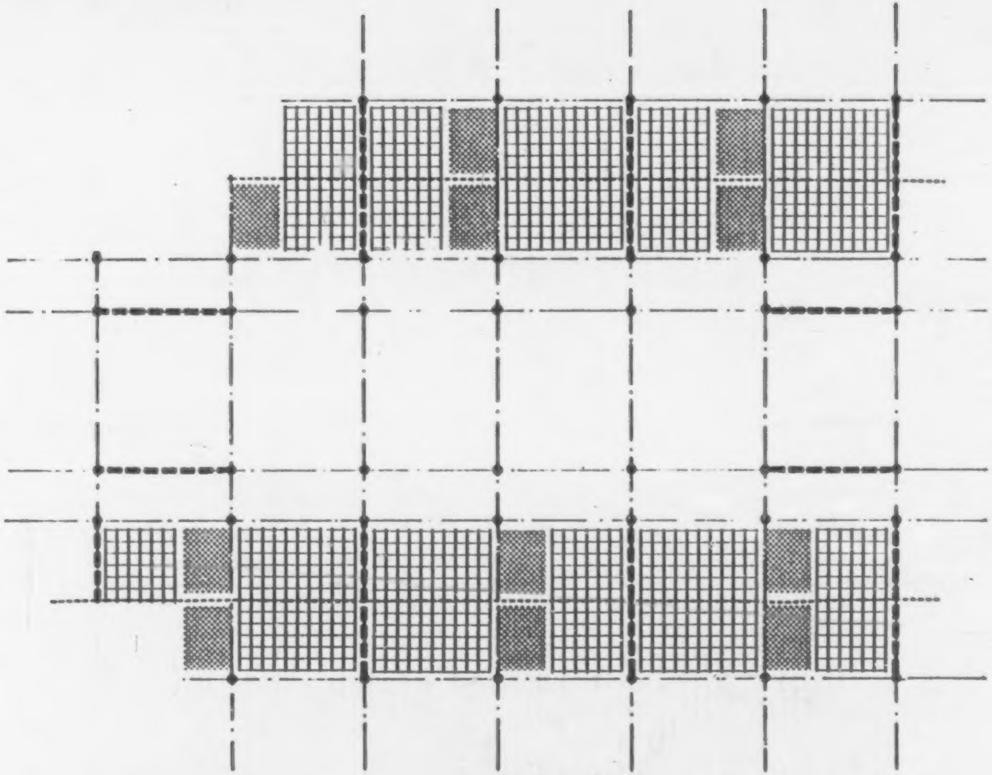
MODULAR NURSING UNIT

flexibility



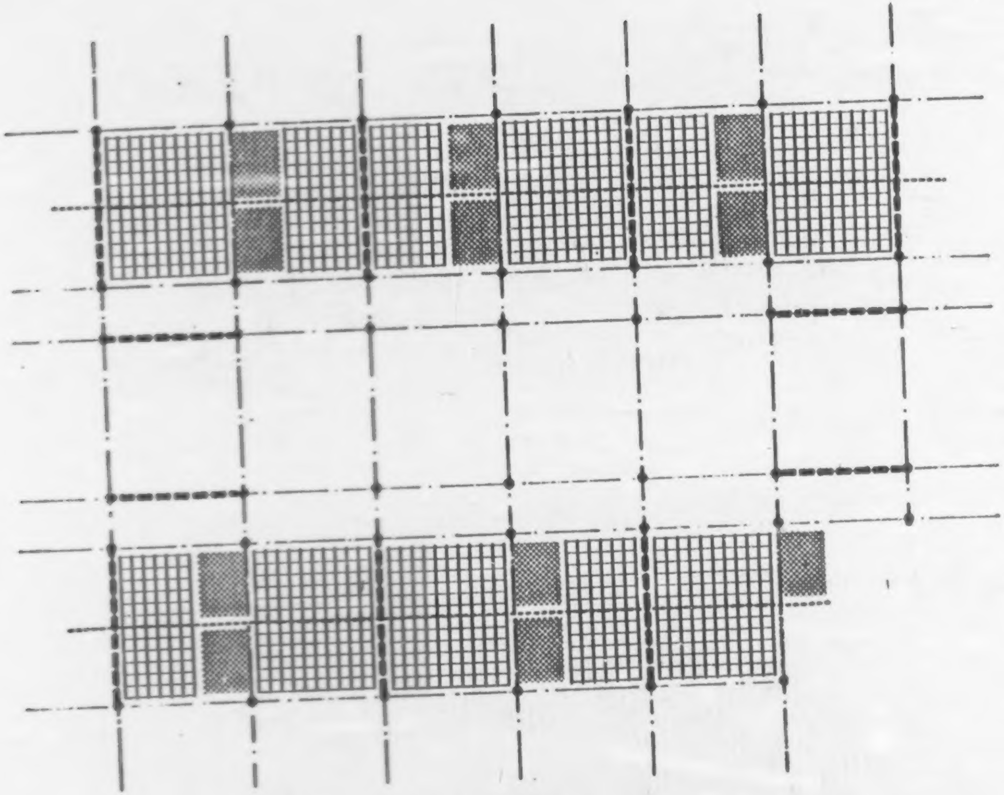
MODULAR NURSING UNIT

flexibility



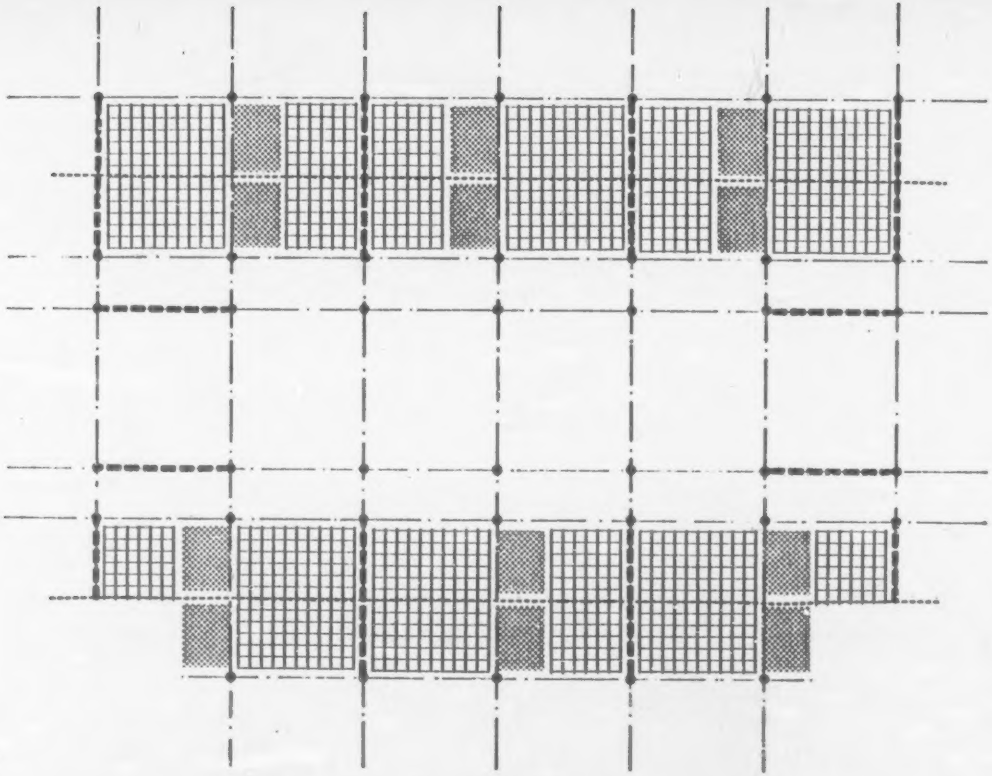
MODULAR NURSING UNIT

flexibility



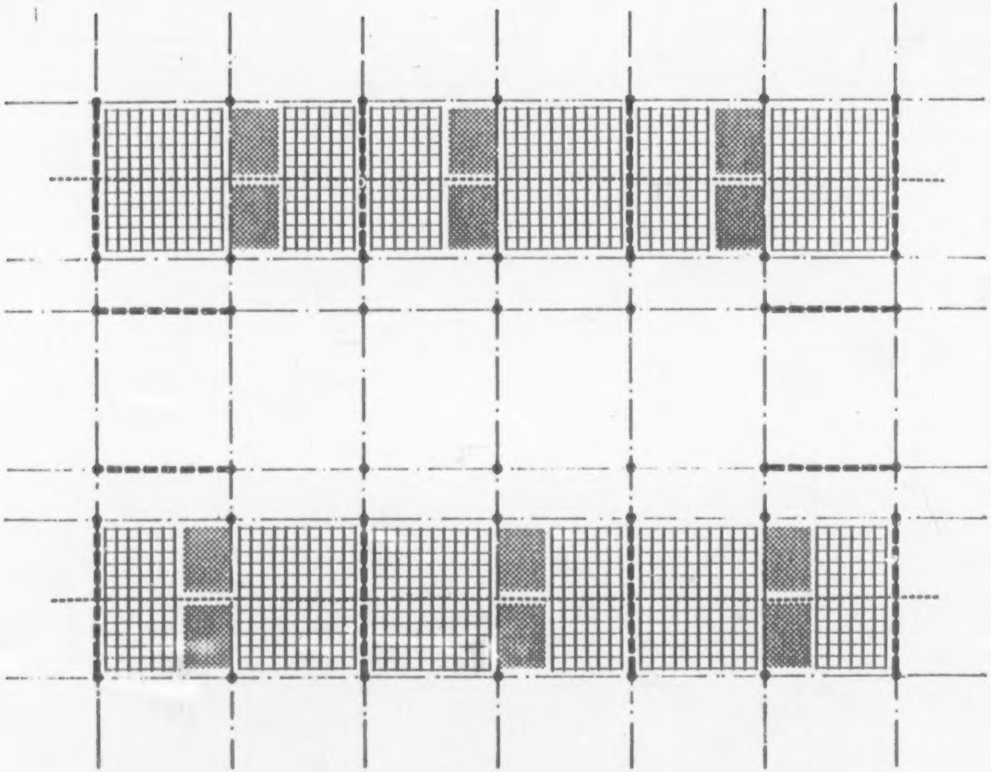
MODULAR NURSING UNIT

flexibility



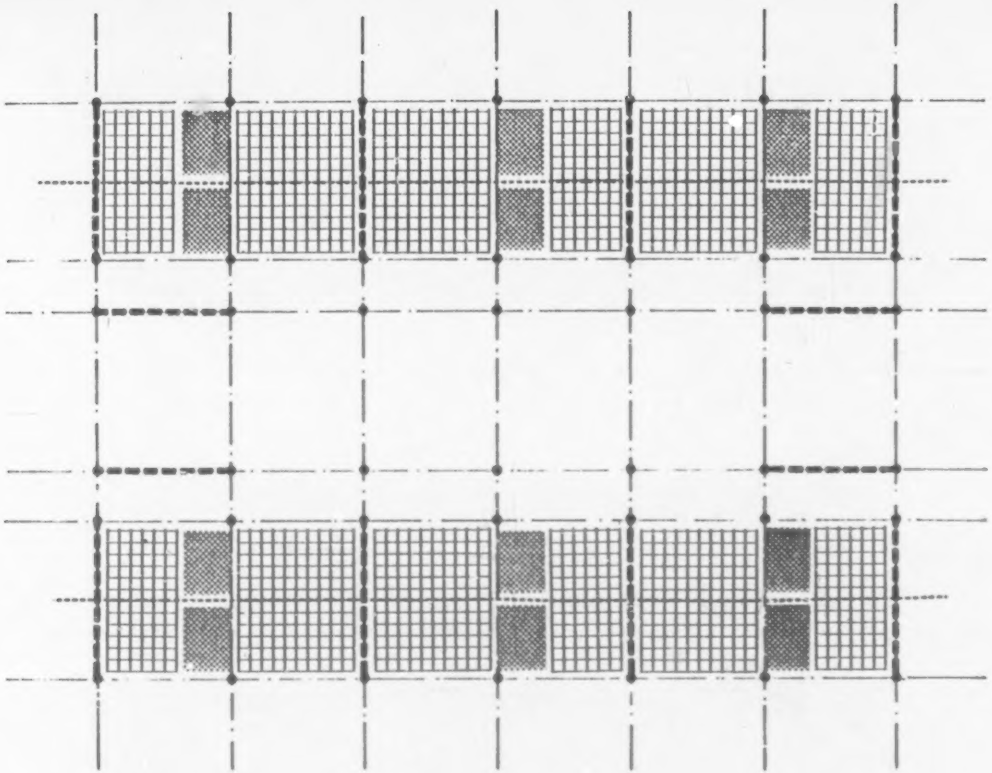
MODULAR NURSING UNIT

flexibility



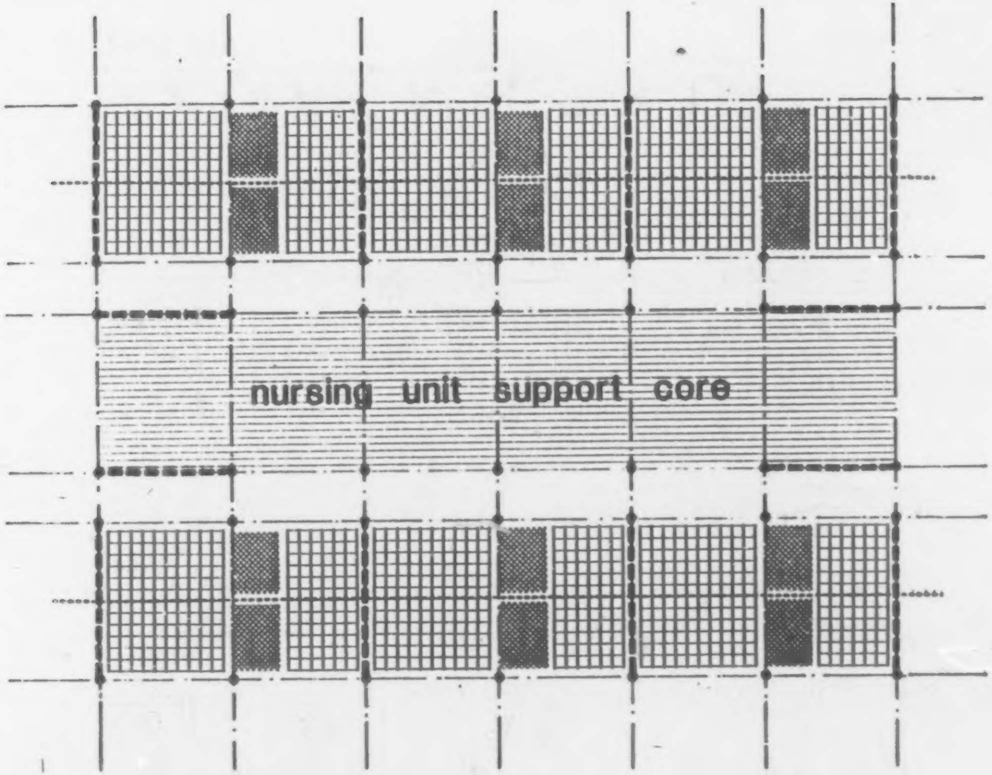
MODULAR NURSING UNIT

flexibility



MODULAR NURSING UNIT

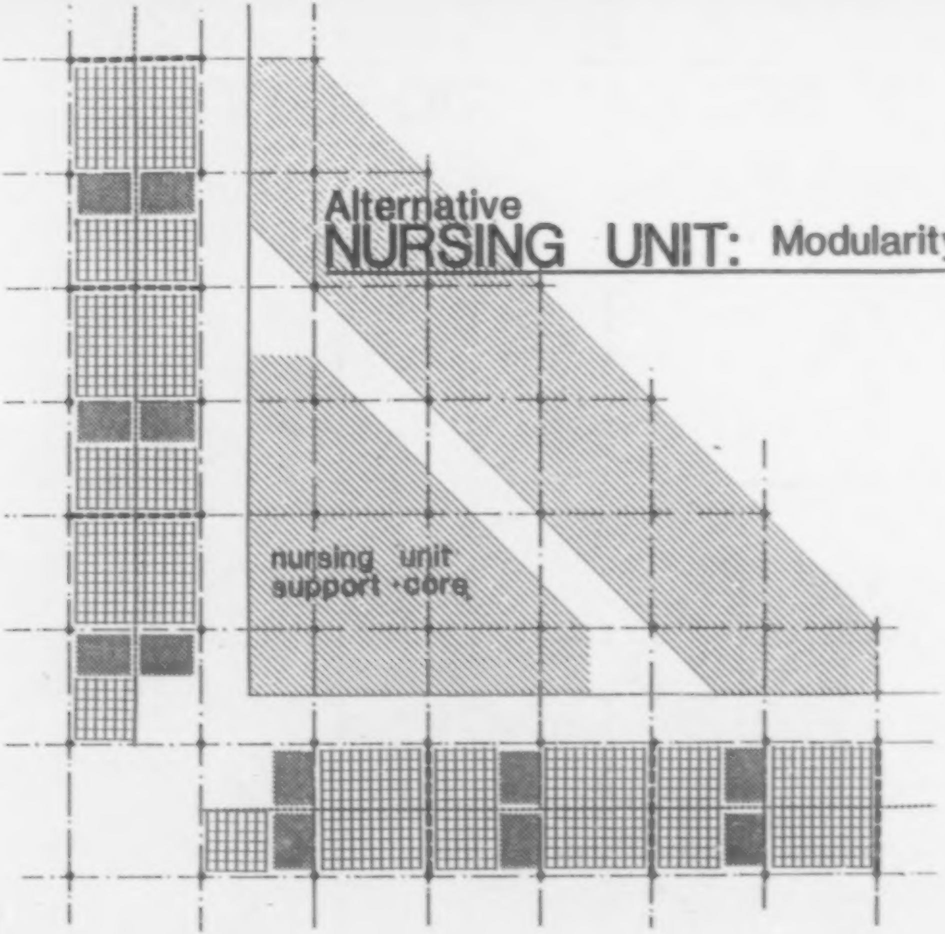
flexibility


nursing unit support core

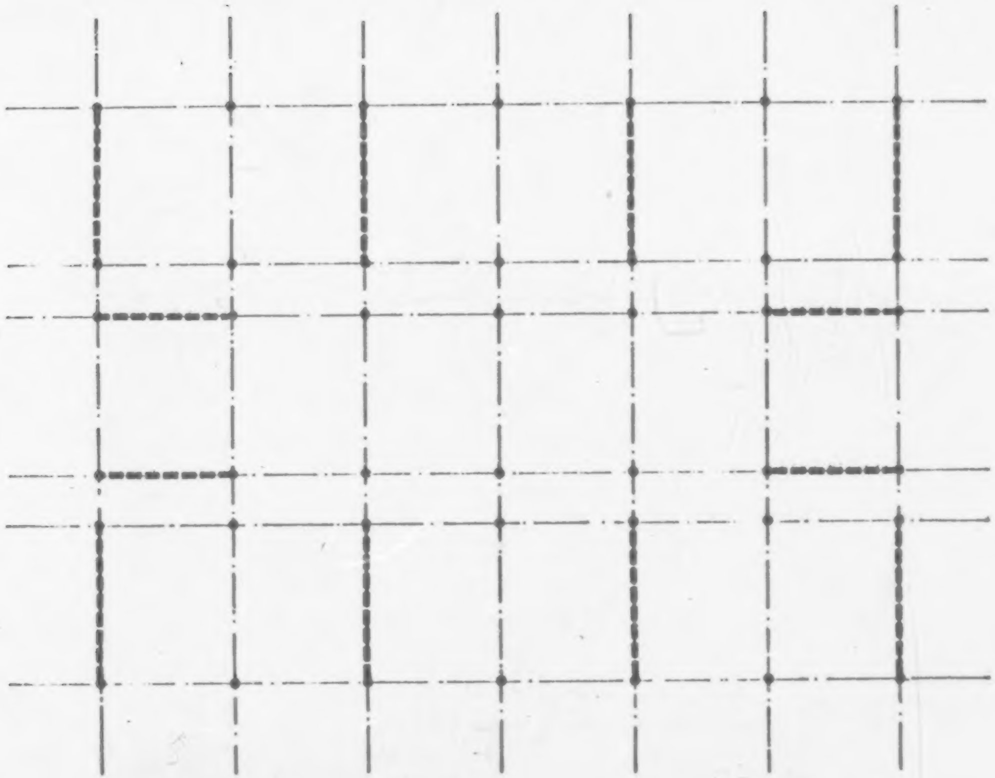
NURSING UNIT: Modularity

bedroom / bathroom modules

Alternative NURSING UNIT: Modularity

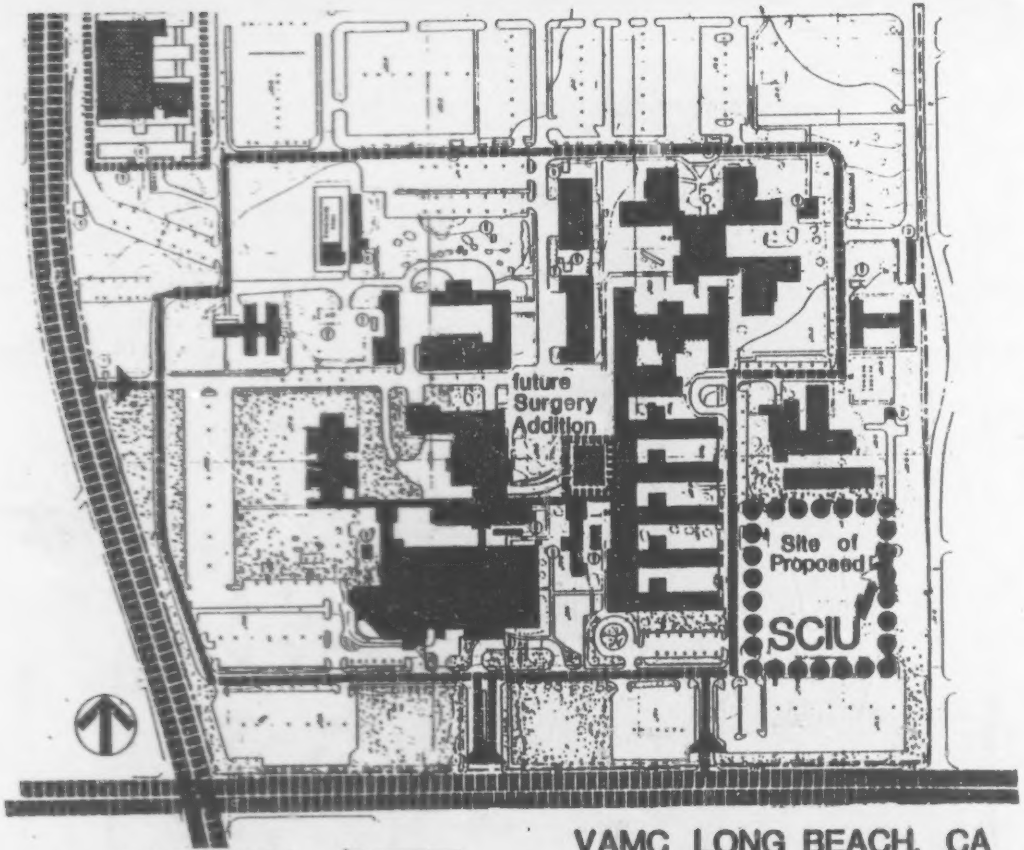


nursing unit
support core



STRUCTURAL SYSTEM

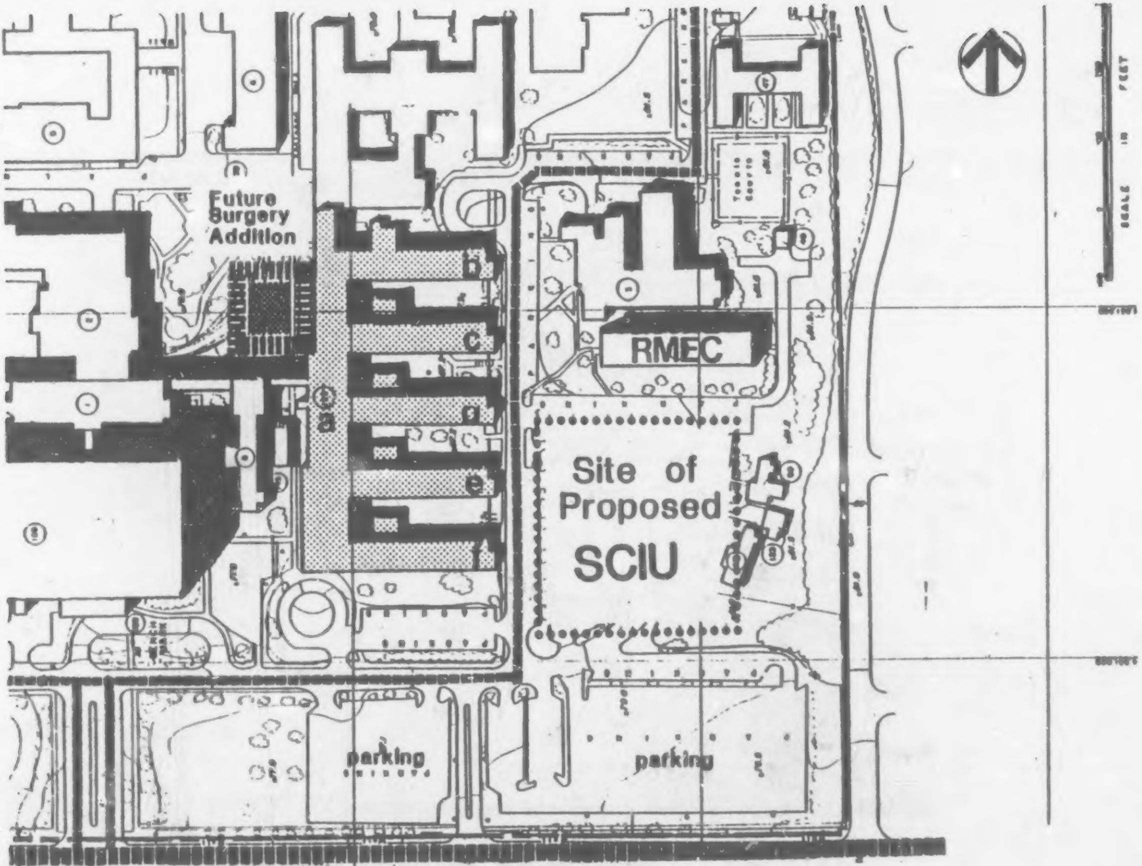
columns / shear walls


future
Surgery
Addition
Site of
Proposed
SCIU

VAMC SITE

VAMC LONG BEACH, CA

160 Bed Spinal Cord Injury Unit & Outpatient Clinic


Future
Surgery
Addition
b
c
d
e
f
RMEC
Site of
Proposed
SCIU
parking
parking
SCALE IN FEET

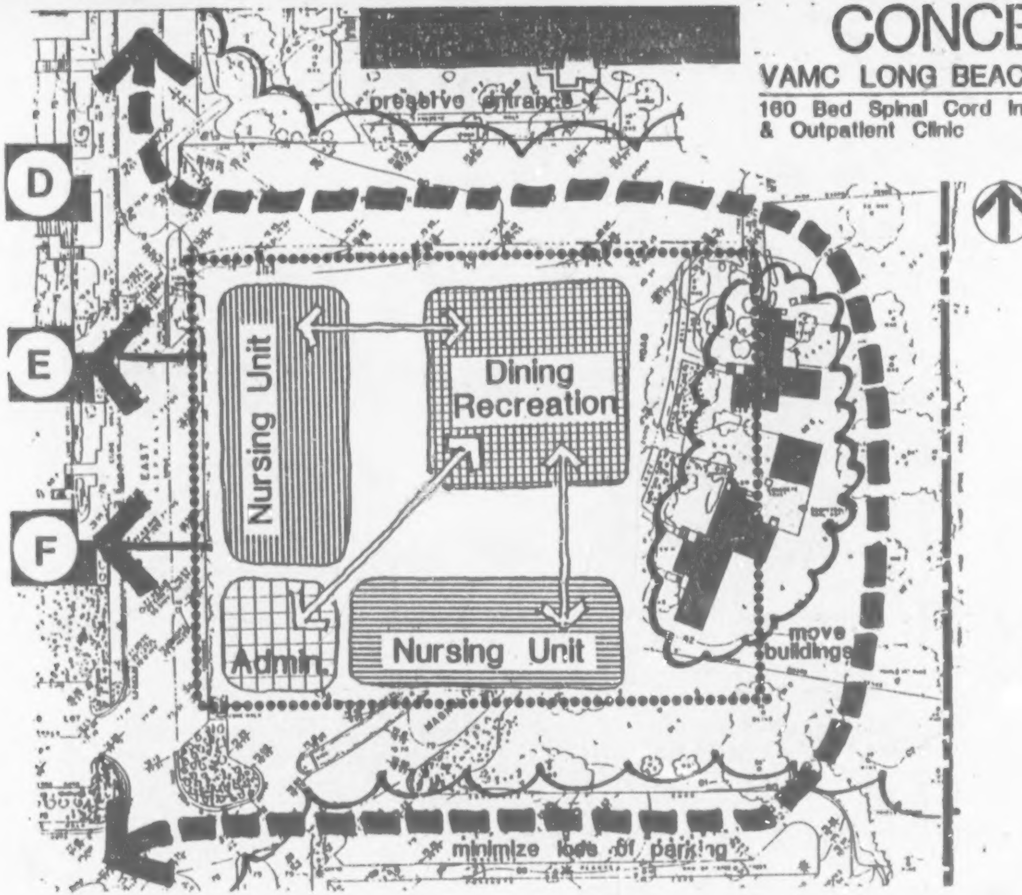
SITE **VAMC LONG BEACH, CA**

160 Bed Spinal Cord Injury Unit
& Outpatient Clinic

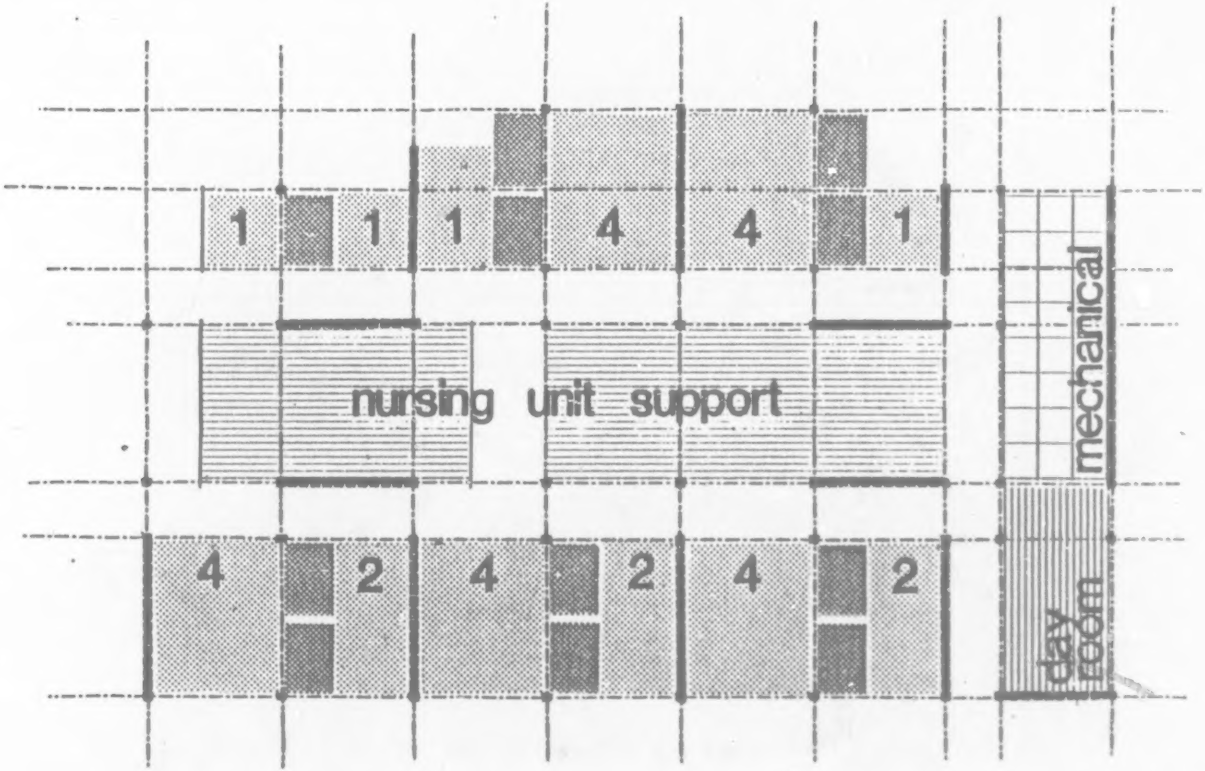
CONCEPT

VAMC LONG BEACH, CA

160 Bed Spinal Cord Injury Unit
& Outpatient Clinic

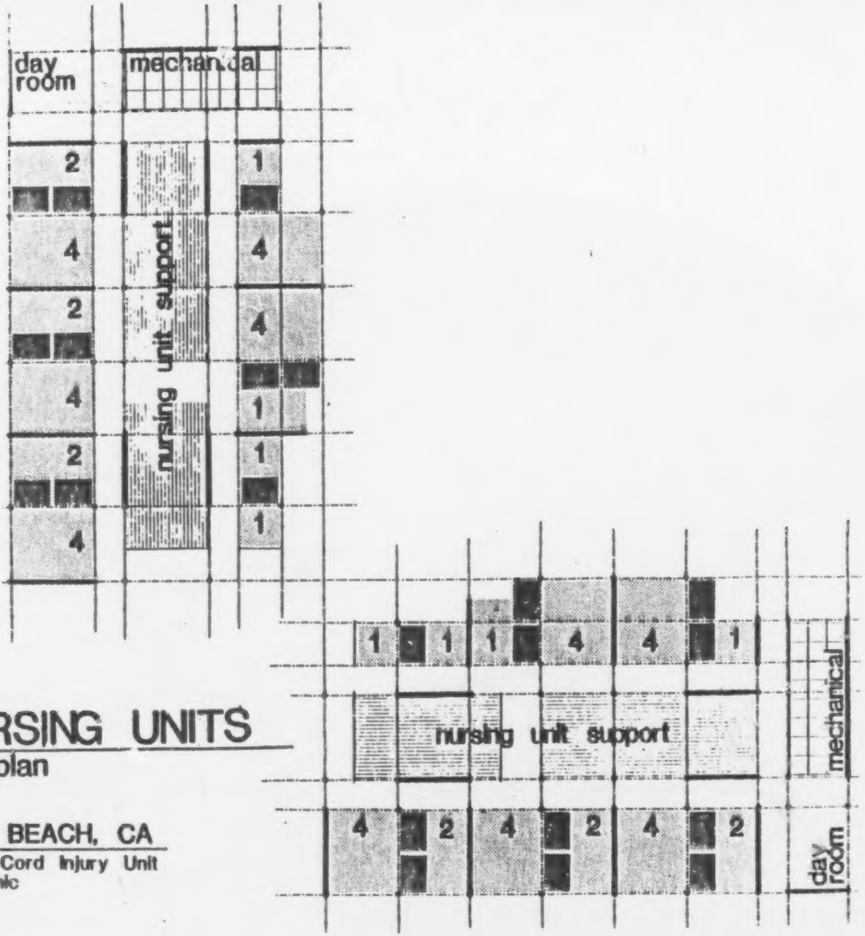


[redacted]
preserve entrance
D
E
F
Nursing Unit
Dining
Recreation
Admin.
Nursing Unit
move
buildings
minimize loss of parking


1
1
1
4
4
1
nursing unit support
mechanical
4
2
4
2
4
2
day room

SCI NURSING UNIT
schematic plan

VAMC LONG BEACH, CA
160 Bed Spinal Cord Injury Unit
& Outpatient Clinic

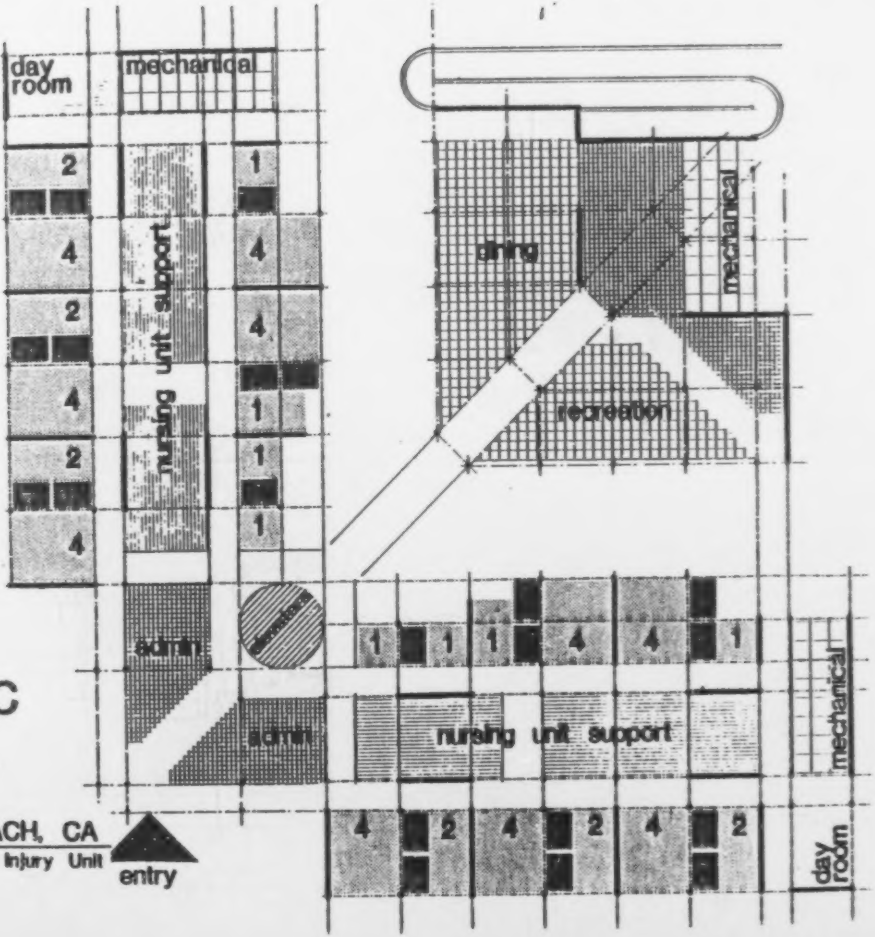

day room
mechanical
2
1
4
4
2
4
4
1
2
1
4
1
nursing unit support
1
1
1
4
4
1
nursing unit support
mechanical
4
2
4
2
4
2
day room

SCI NURSING UNITS

schematic plan

VAMC LONG BEACH, CA

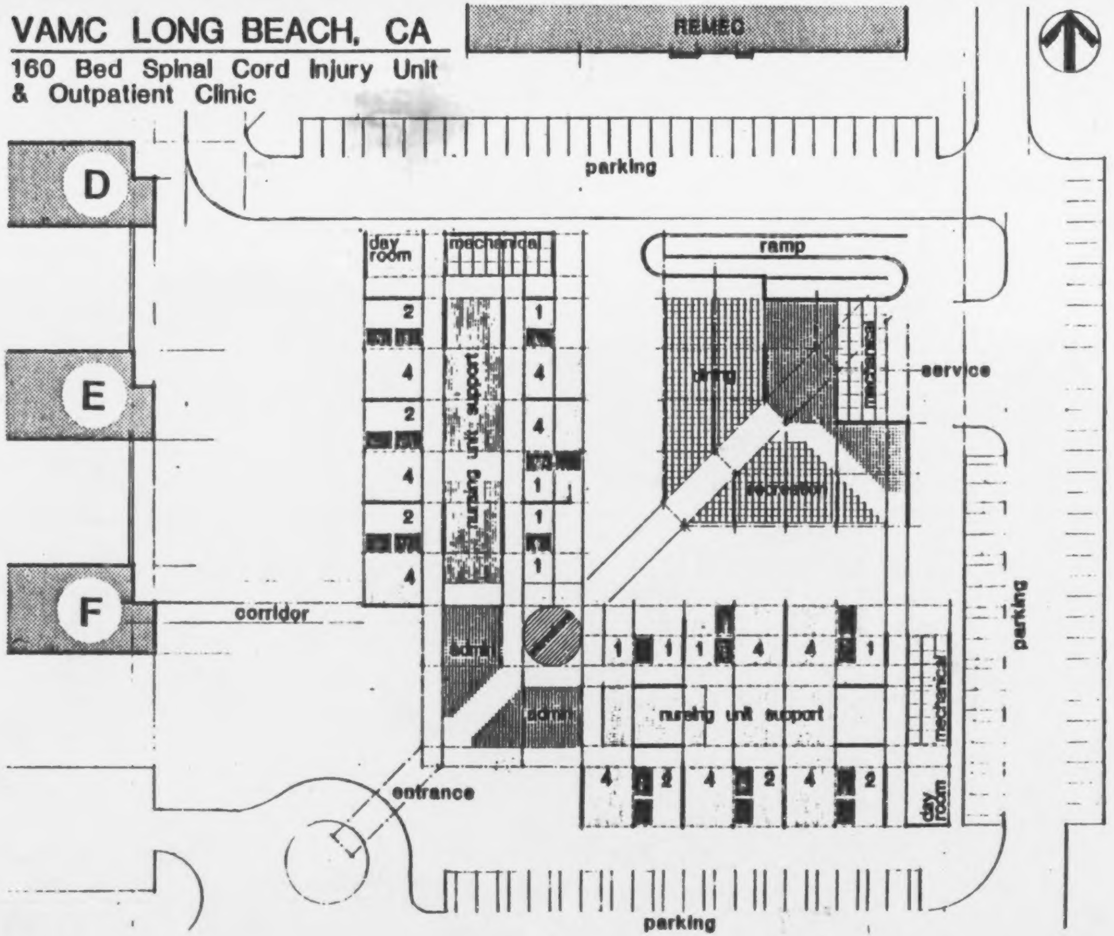
160 Bed Spinal Cord Injury Unit
& Outpatient Clinic


day room
mechanical
2
4
2
4
2
4
nursing unit support
1
4
4
1
1
1
dining
mechanical
recreation
admin
admin
1
1
1
4
4
1
nursing unit support
mechanical
4
2
4
2
4
2
day room
entry

SCHEMATIC PLAN

VAMC LONG BEACH, CA

160 Bed Spinal Cord Injury Unit
& Outpatient Clinic



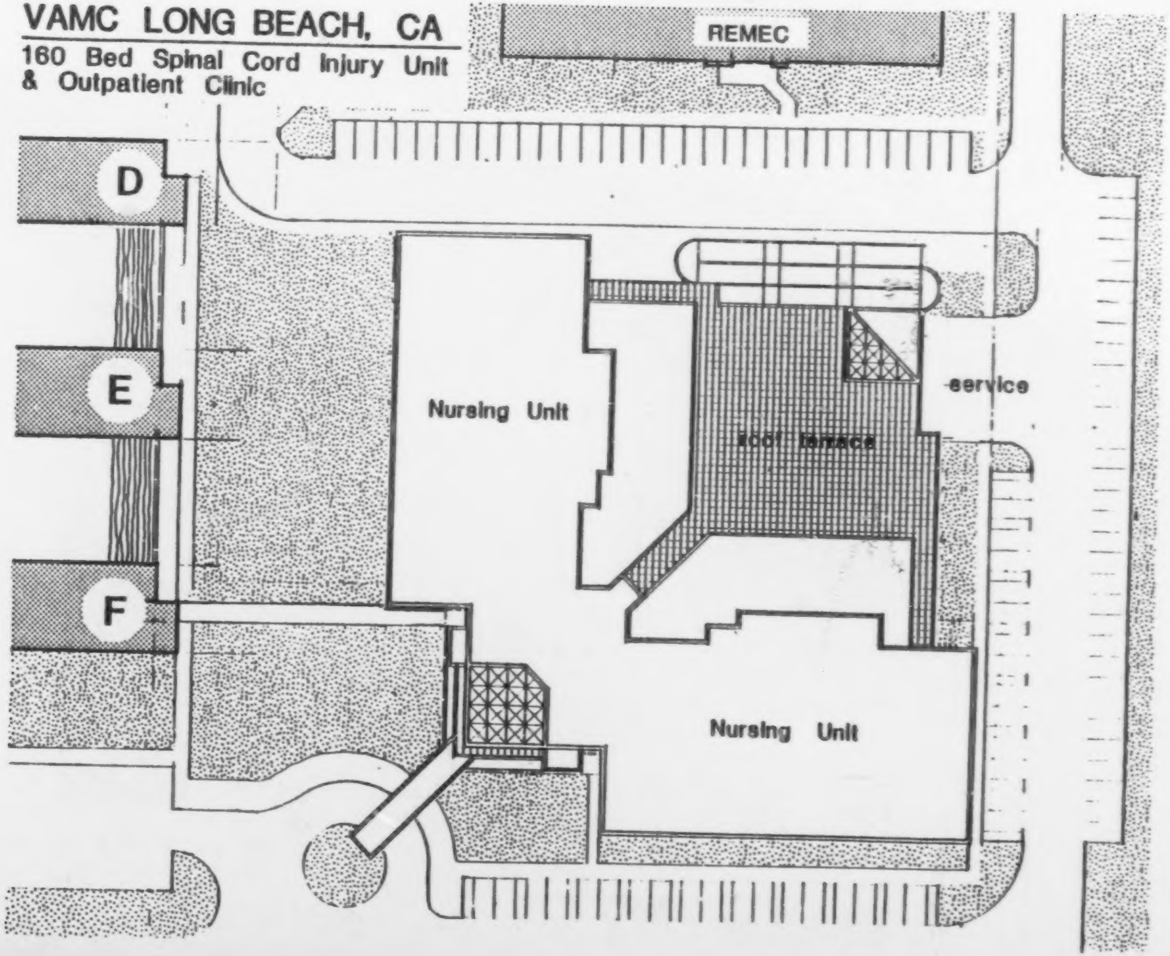
VAMC LONG BEACH, CA

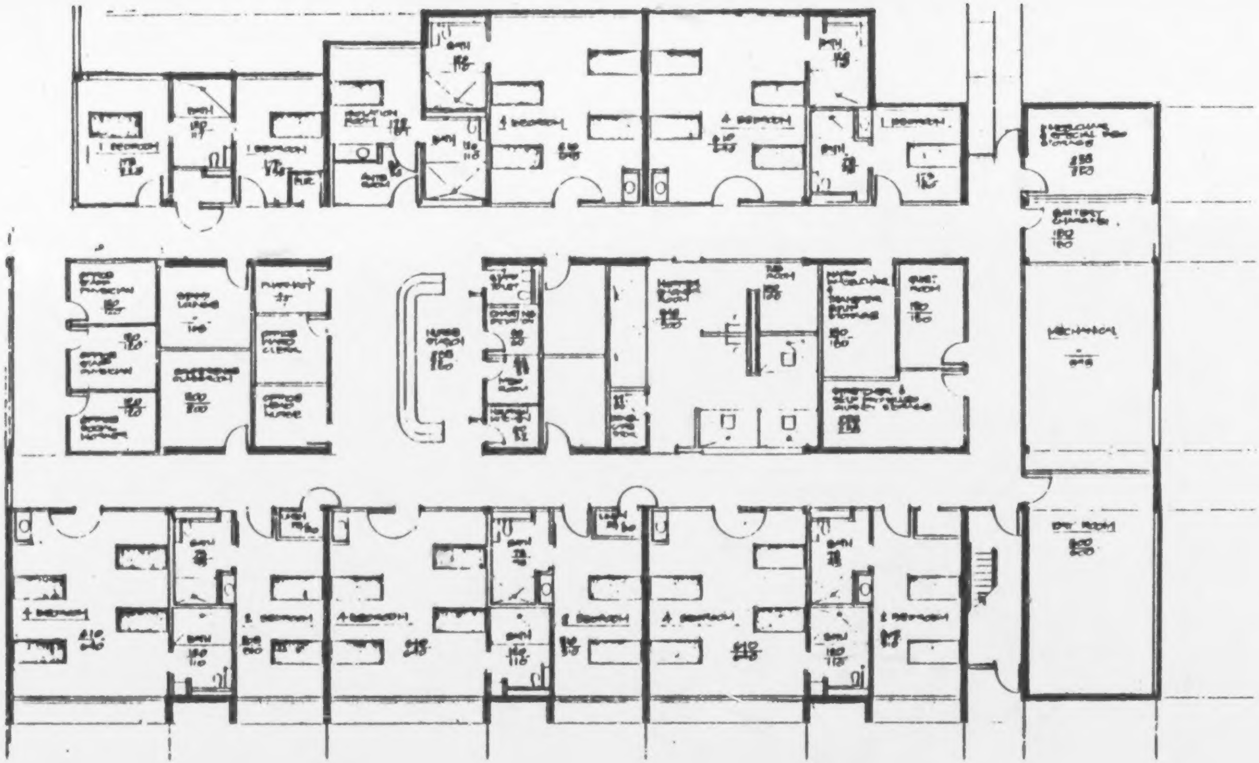
160 Bed Spinal Cord Injury Unit
& Outpatient Clinic

REMEC
parking
D
E
F
corridor
day room
mechanical
2
4
1
nursing unit support
ramp
dining
mechanical
service
recreation
admin
admin
nursing unit support
mechanical
day room
entrance
parking
parking

VAMC LONG BEACH, CA

160 Bed Spinal Cord Injury Unit
& Outpatient Clinic


REMEC
D
E
F
Nursing Unit
roof terrace
service
Nursing Unit

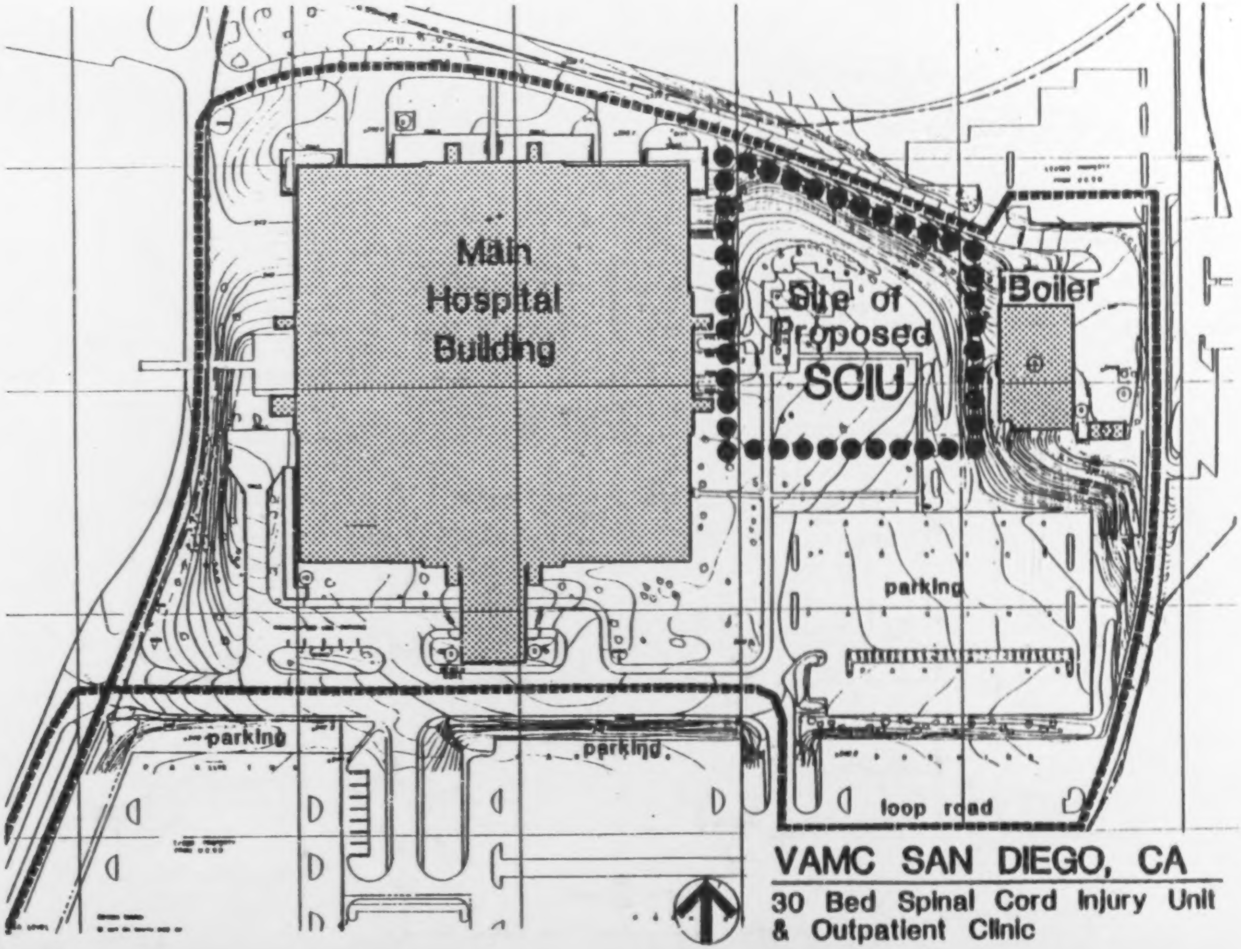


SCI NURSING UNIT

preliminary design

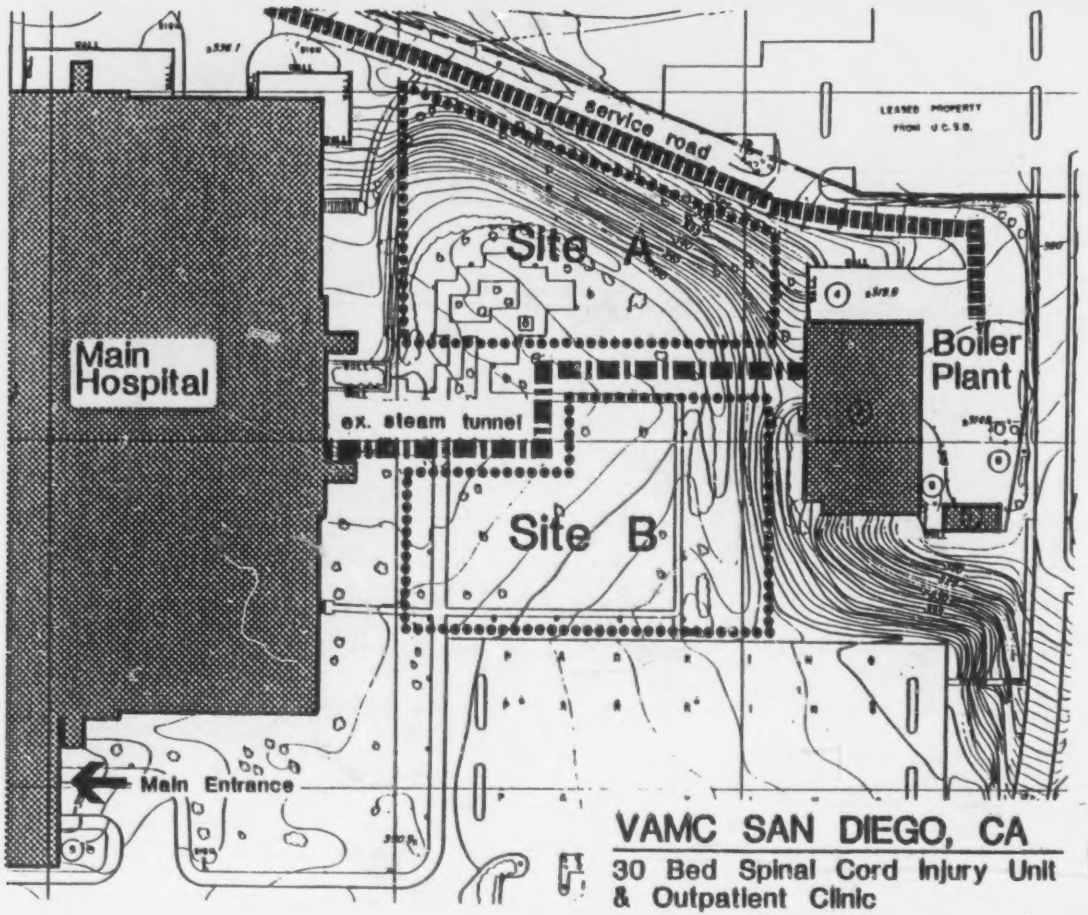
VAMC LONG BEACH, CA

160 Bed Spinal Cord Injury Unit
& Outpatient Clinic


Main Hospital Building
Site of Proposed SCIU
Boiler
parking
parking
parking
loop road

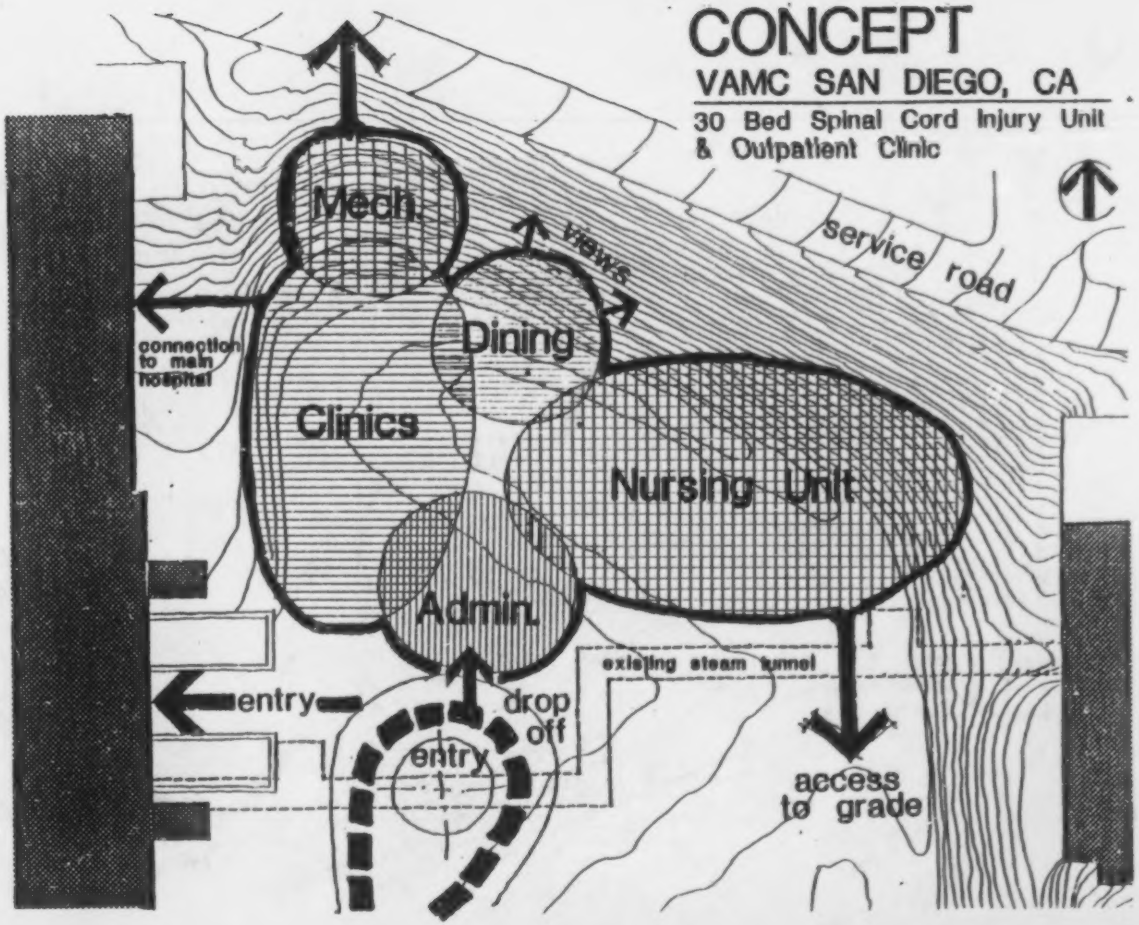
VAMC SAN DIEGO, CA

30 Bed Spinal Cord Injury Unit & Outpatient Clinic


LEASED PROPERTY FROM U.C.S.D.
service road
Site A
Main Hospital
Boiler Plant
ex. steam tunnel
Site B
Main Entrance

VAMC SAN DIEGO, CA

30 Bed Spinal Cord Injury Unit & Outpatient Clinic

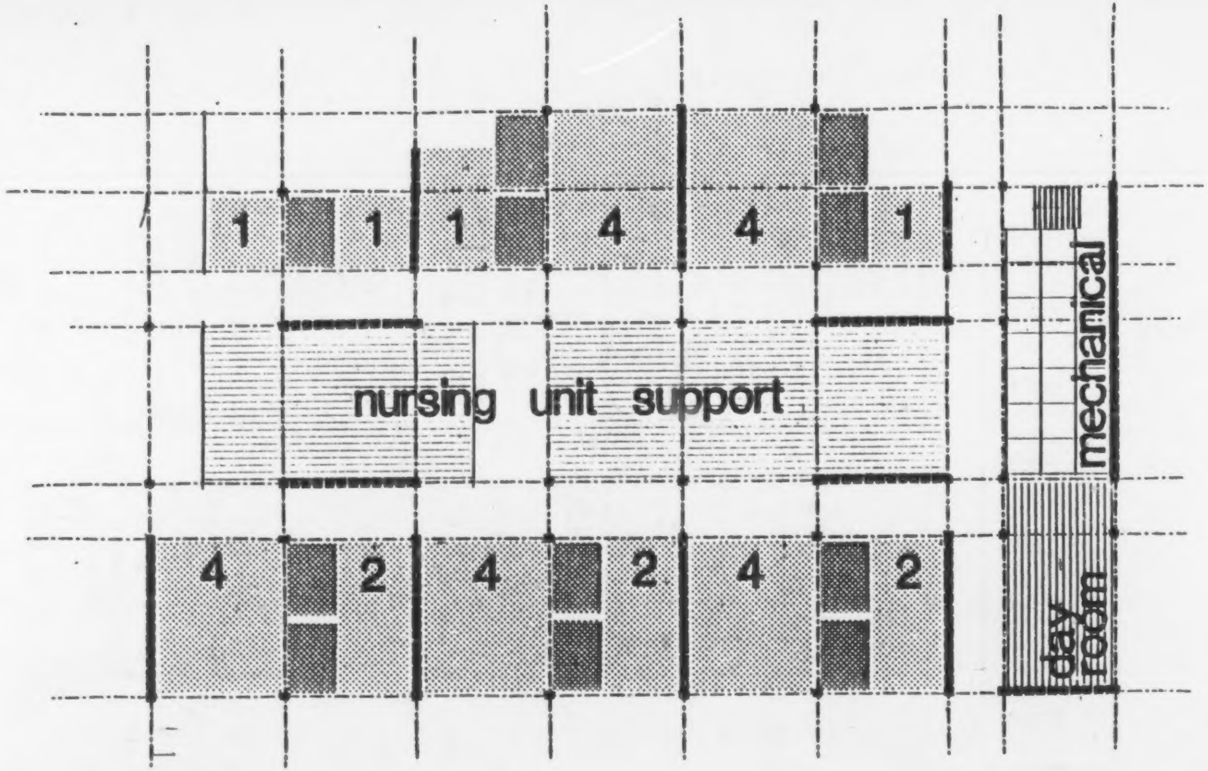


CONCEPT

VAMC SAN DIEGO, CA

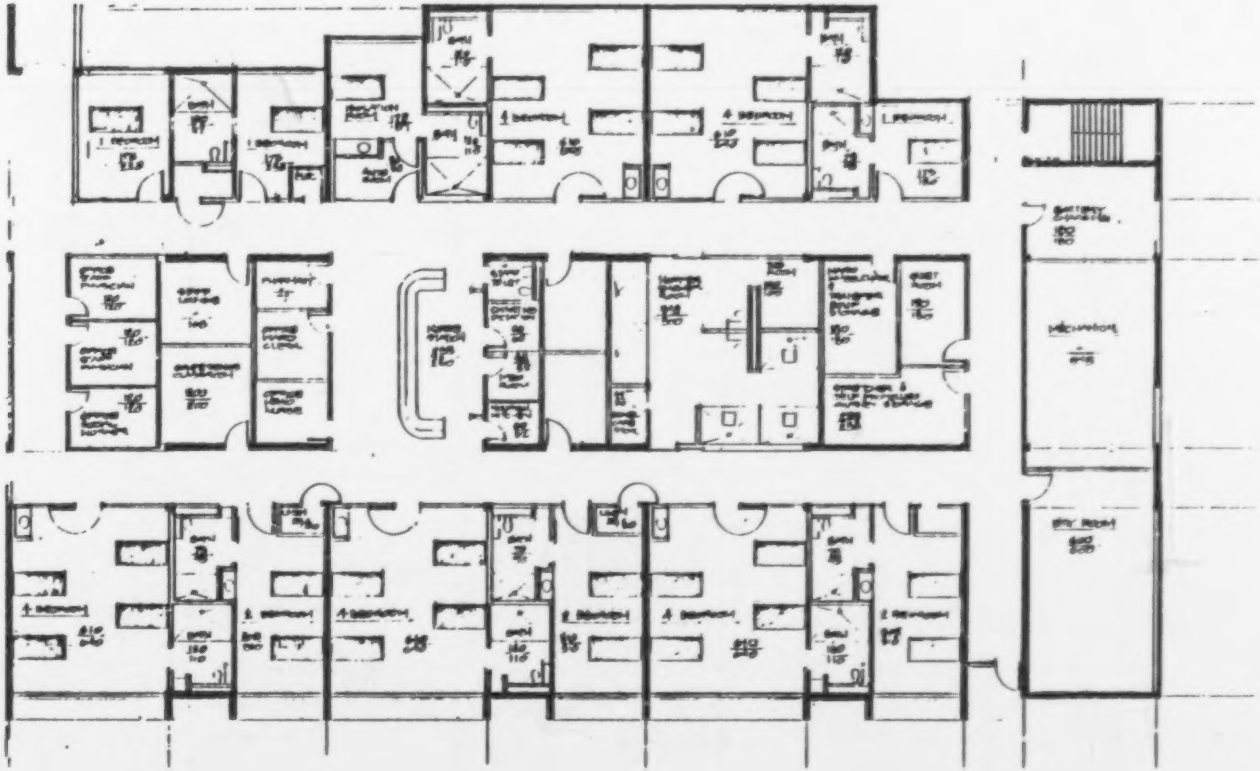
30 Bed Spinal Cord Injury Unit
& Outpatient Clinic

Mech.
views
service road
Dining
connection to main hospital
Clinics
Nursing Unit
Admin.
existing steam tunnel
entry
drop off
entry
access to grade


1
1
1
4
4
1
nursing unit support
mechanical
4
2
4
2
4
2
day room

NURSING UNIT
schematic plan

VAMC SAN DIEGO, CA
30 Bed Spinal Cord Injury Unit
& Outpatient Clinic



SCI NURSING UNIT

preliminary design

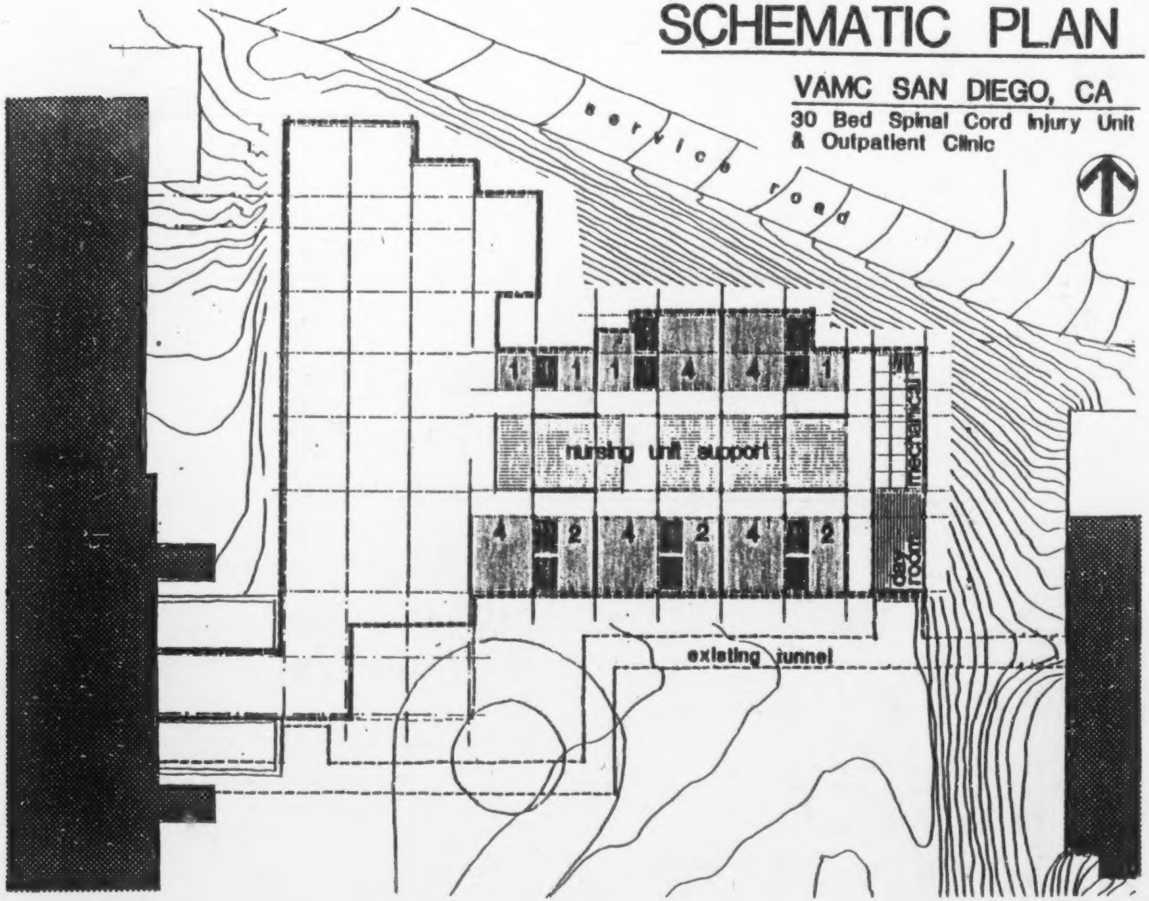
VAMC SAN DIEGO, CA

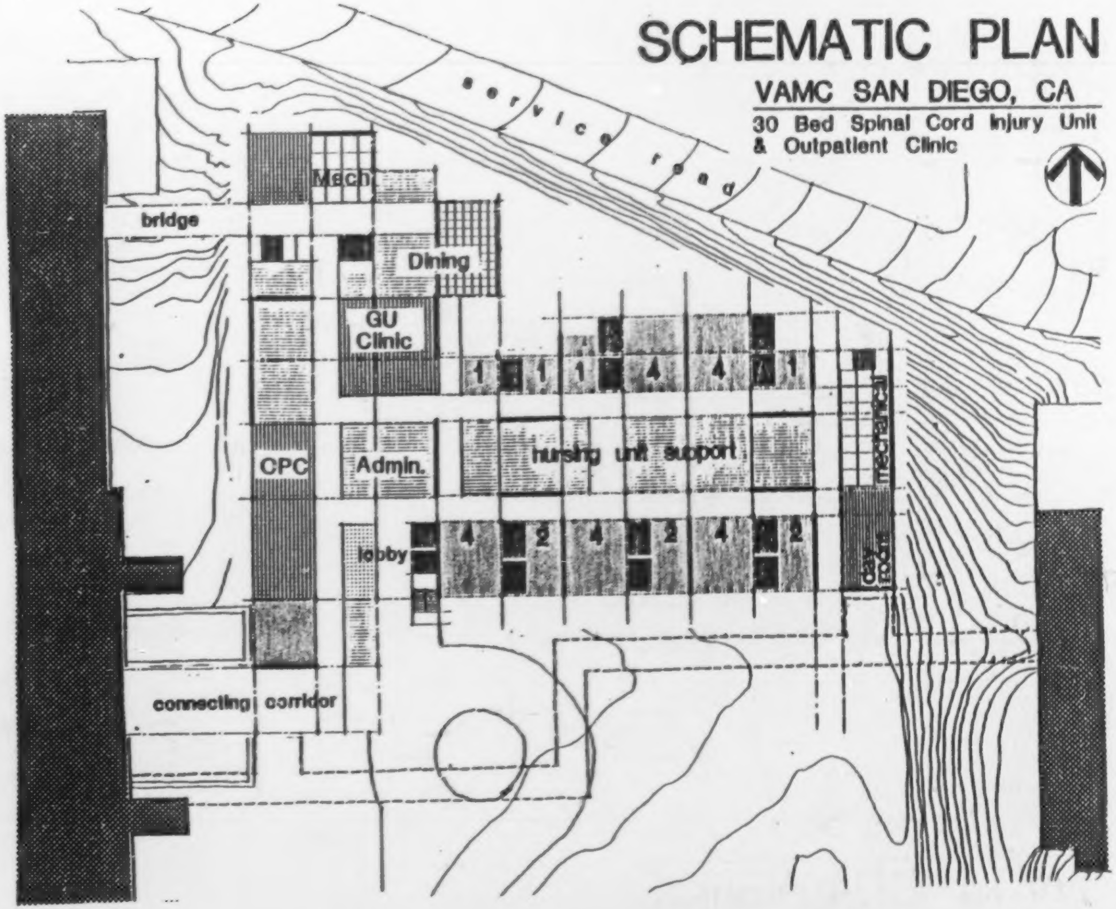
30 Bed Spinal Cord Injury Unit
& Outpatient Clinic

SCHEMATIC PLAN

VAMC SAN DIEGO, CA

30 Bed Spinal Cord Injury Unit & Outpatient Clinic


service road
1
1
1
1
4
4
1
nursing unit support
mechanical
4
2
4
2
4
2
day room
existing tunnel

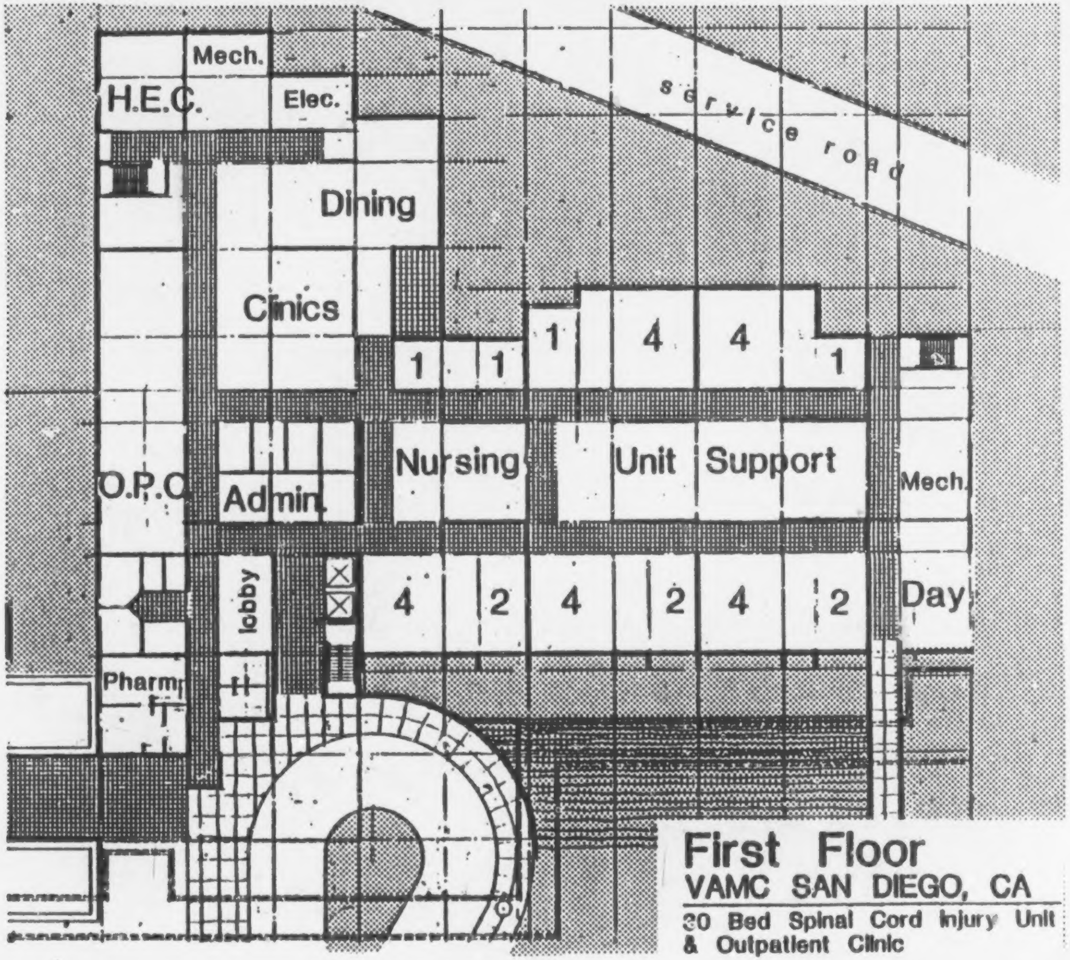


SCHEMATIC PLAN

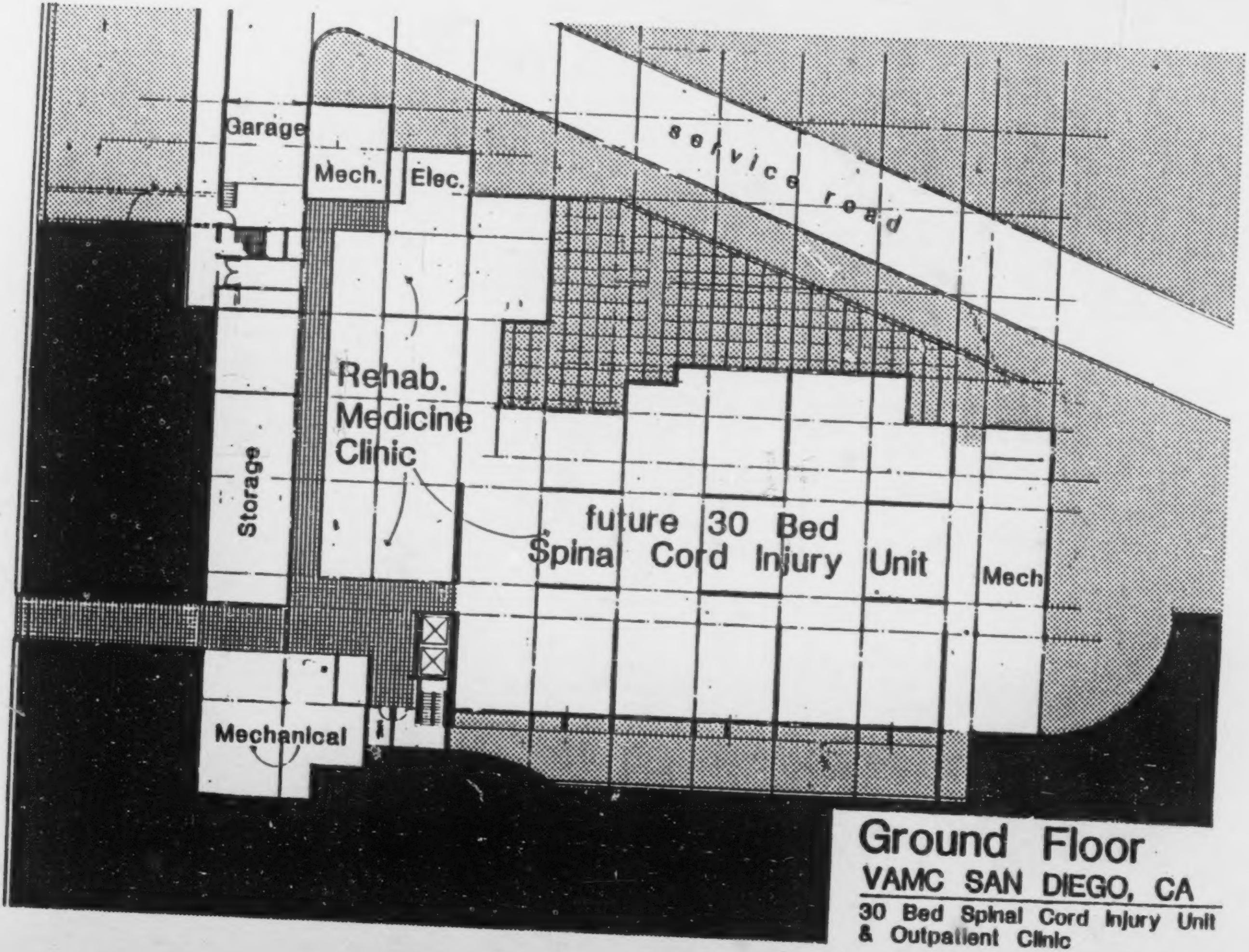
VAMC SAN DIEGO, CA

30 Bed Spinal Cord Injury Unit
& Outpatient Clinic

service road
Mech.
bridge
Dining
GU
Clinic
1
1
1
4
4
1
CPC
Admin.
nursing unit support
mechanical
lobby
4
2
4
2
4
2
day room
connecting corridor


Mech.
H.E.C.
Elec.
service road
Dining
Clinics
1
1
1
4
4
1
O.P.C.
Admin.
Nursing
Unit
Support
Mech.
lobby
4
2
4
2
4
2
Day
Pharm

First Floor
VAMC SAN DIEGO, CA
30 Bed Spinal Cord Injury Unit & Outpatient Clinic


Garage
Mech.
Elec.
service road
Rehab.
Medicine
Clinic
Storage
future 30 Bed
Spinal Cord Injury Unit
Mech
Mechanical

Ground Floor

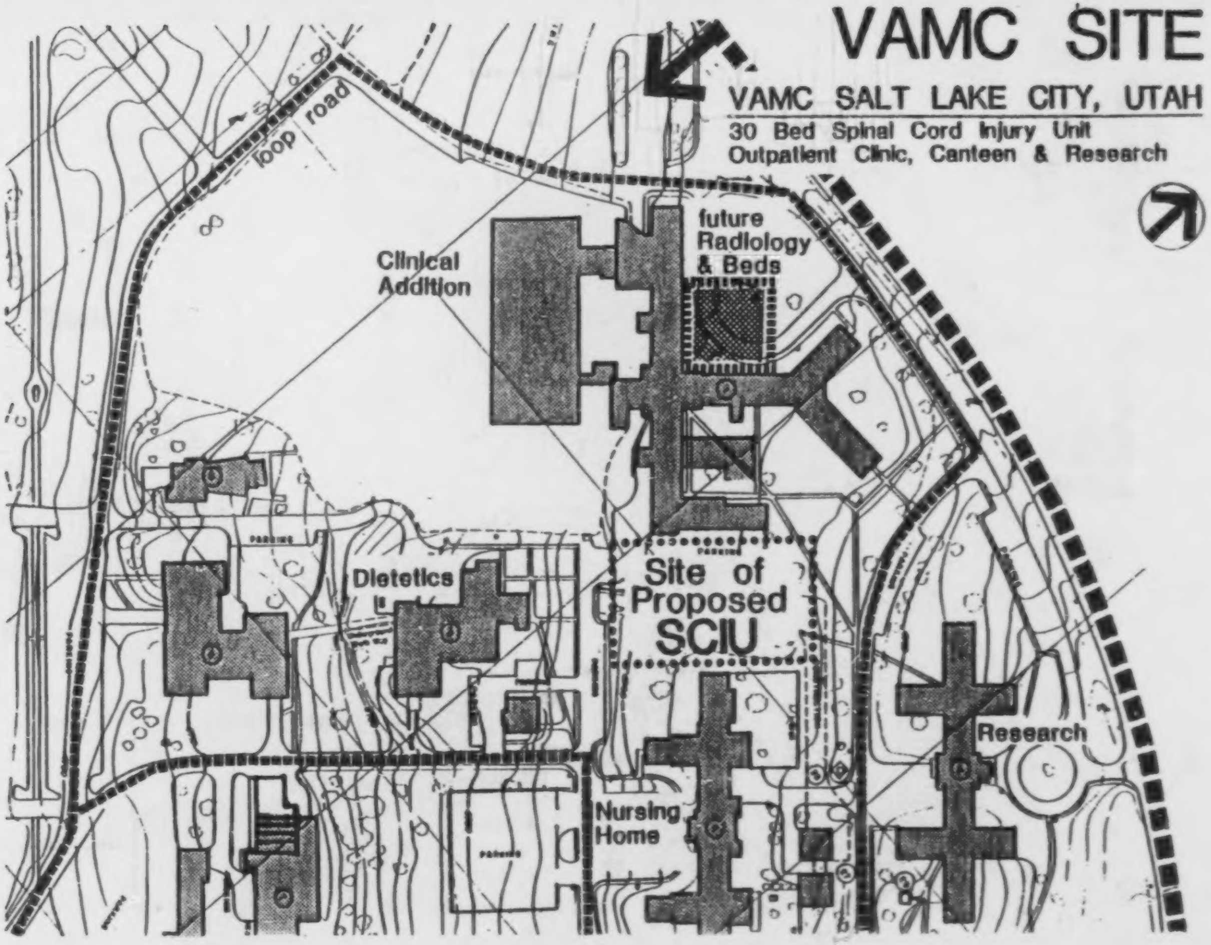
VAMC SAN DIEGO, CA

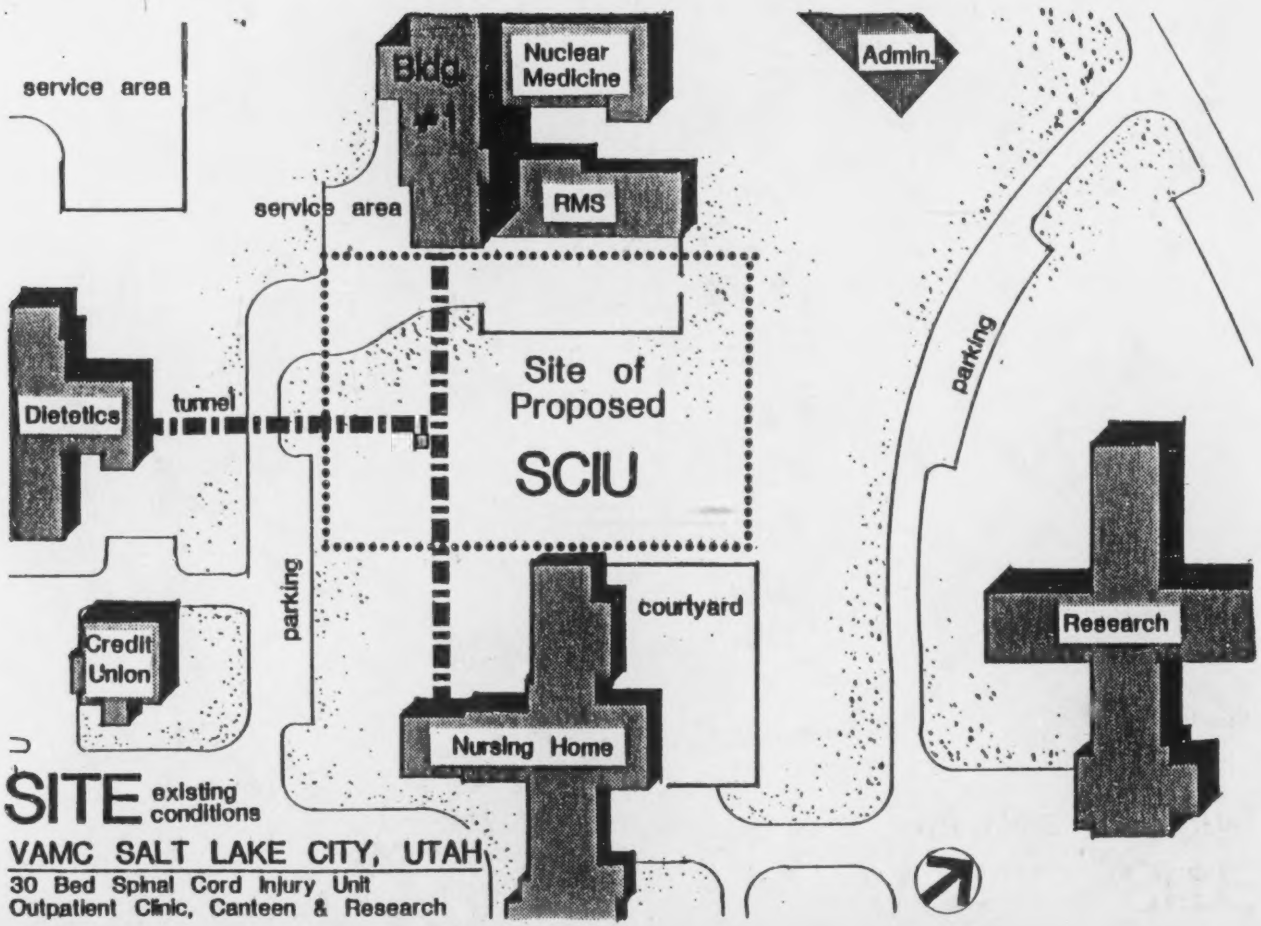
30 Bed Spinal Cord Injury Unit & Outpatient Clinic

VAMC SITE

VAMC SALT LAKE CITY, UTAH

30 Bed Spinal Cord Injury Unit
Outpatient Clinic, Canteen & Research

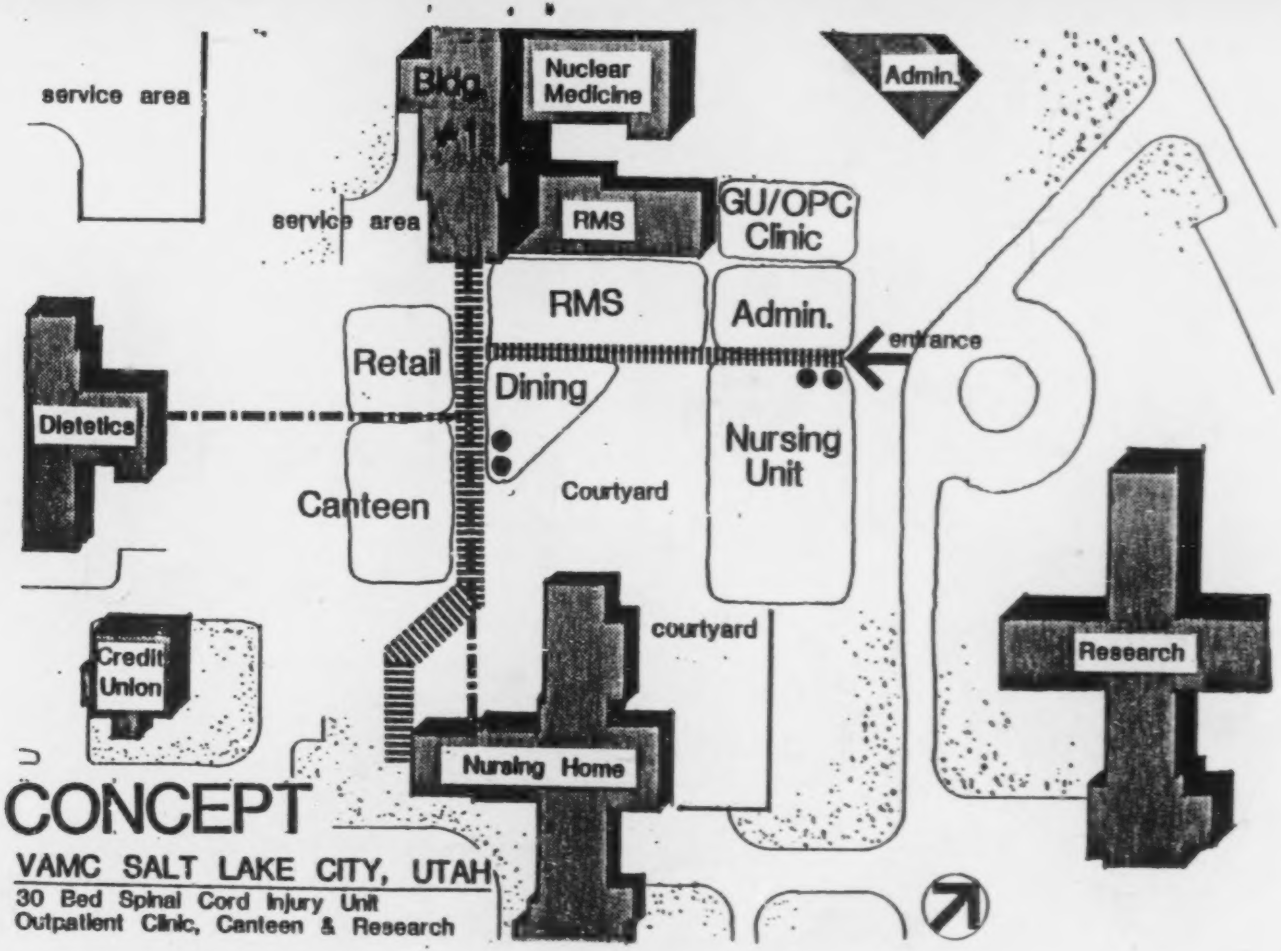

loop road
Clinical Addition
future Radiology & Beds
Site of Proposed SCIU
Dietetics
Nursing Home
Research
PARKING


service area
Bldg. #1
Nuclear Medicine
Admin.
service area
RMS
Dietetics
tunnel
Site of Proposed SCIU
parking
parking
courtyard
Research
Credit Union
Nursing Home

SITE existing conditions

VAMC SALT LAKE CITY, UTAH

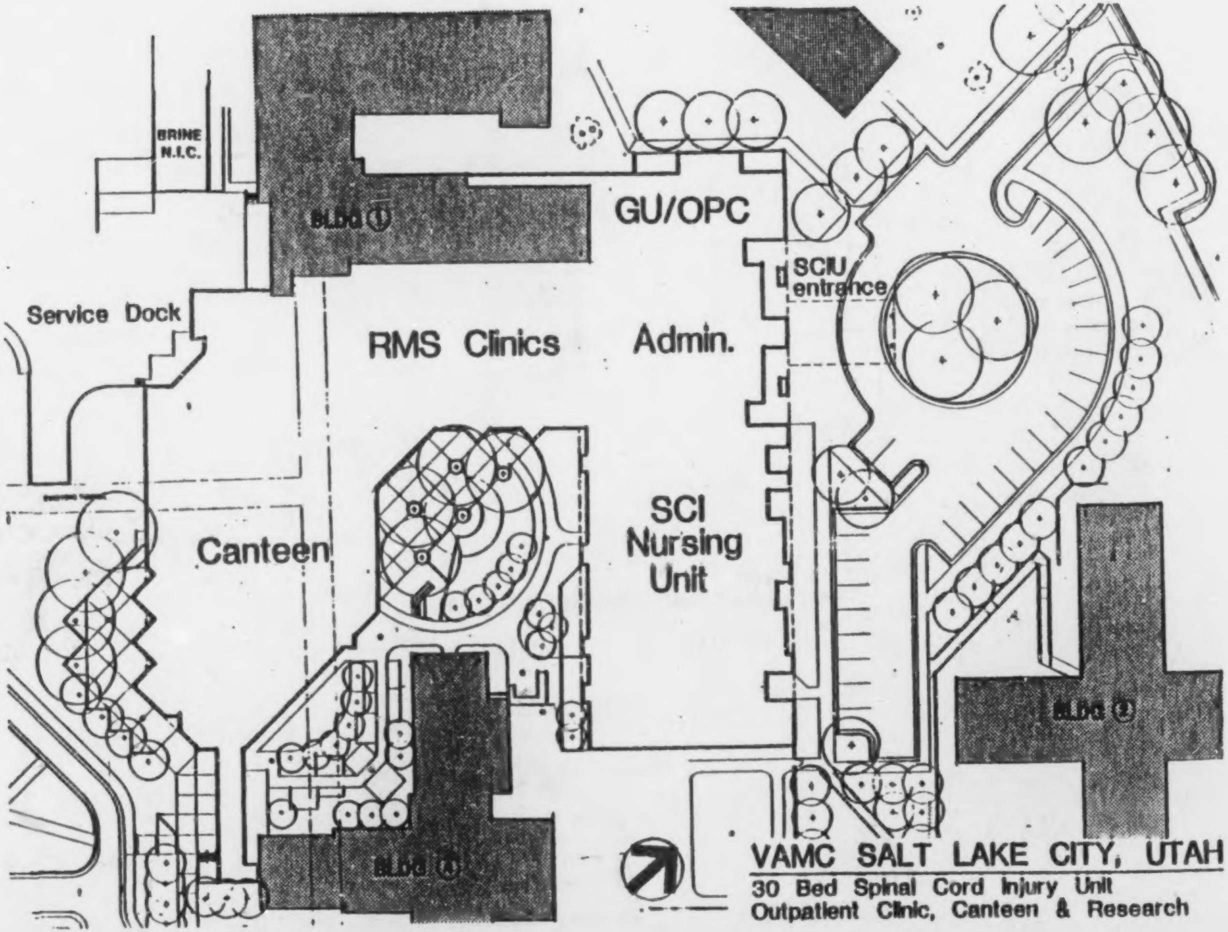
30 Bed Spinal Cord Injury Unit
Outpatient Clinic, Canteen & Research


service area
Bldg.
Nuclear Medicine
Admin.
service area
RMS
GU/OPC Clinic
RMS
Admin.
entrance
Retail
Dining
Dietetics
Nursing Unit
Courtyard
Canteen
courtyard
Research
Credit Union
Nursing Home

CONCEPT

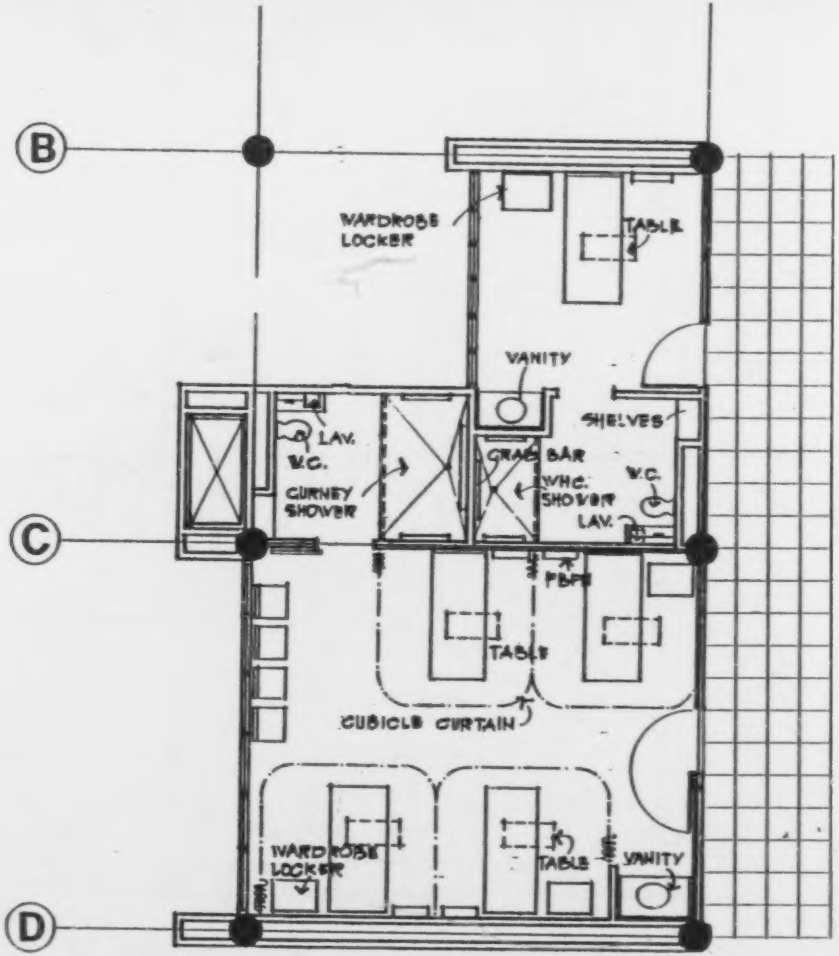
VAMC SALT LAKE CITY, UTAH

30 Bed Spinal Cord Injury Unit
Outpatient Clinic, Canteen & Research


BRINE
N.I.C.
BLDG ①
GU/OPC
SCIU
entrance
Service Dock
RMS Clinics
Admin.
SCI
Nursing
Unit
Canteen
BLDG ②
BLDG ④

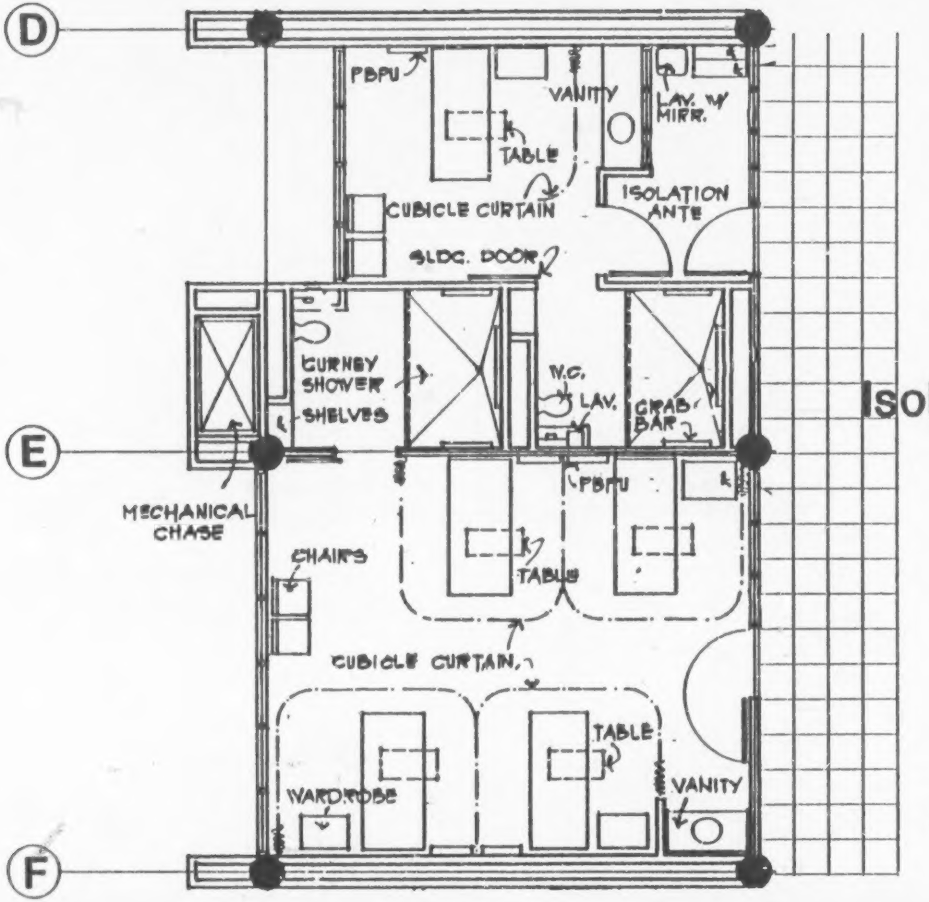
VAMC SALT LAKE CITY, UTAH

30 Bed Spinal Cord Injury Unit
Outpatient Clinic, Canteen & Research


B
WARDROBE LOCKER
TABLE
VANITY
SHELVES
LAV.
W.C.
GURNEY SHOWER
GRAB BAR
WHC. SHOWER
W.C.
LAV.
C
PBPS
TABLE
CUBICLE CURTAIN
WARDROBE LOCKER
TABLE
VANITY
D

1 Bedroom
w/ wheelchair shower

4 Bedroom
w/ gurney shower


D
PBPU
VANITY
LAV. W/ MIRR.
TABLE
ISOLATION ANTE
CUBICLE CURTAIN
SLDG. DOOR
GURNEY SHOWER
SHELVES
W.C.
LAV.
GRAB BAR
E
MECHANICAL CHASE
PBPU
CHAIRS
TABLE
CUBICLE CURTAIN
TABLE
WARDROBE
VANITY
F

Isolation Room

w/ gurney shower

4 Bedroom

w/ gurney shower

Veterans
Administration

Memorandum

Date JAN 3 1986

From Inspector General (50)

Subj Review of Prototype Nursing Home Care Unit Plans

To Administrator (00)

1. INTRODUCTION

a. Purpose: In response to your December 5, 1985 memorandum, we have reviewed expressed concerns regarding the development of a prototype nursing home care unit (NHCU). In summary, the concerns relate primarily to the existence of suitable prototype nursing home plans. The concerns suggest that the Office of Construction (O/C) has concealed planning, design, and construction errors and bad judgments through obfuscation, denial, and fabrication.

b. Summary: Our review showed that the Veterans Administration (VA) has not yet accomplished its major program initiative of developing a nursing home care unit prototype that provides quality, timely, and cost-effective facilities to meet the long-term needs of aging veterans. Owing to design changes recommended by the Department of Medicine and Surgery (DM&S) program staff, development of an initially approved "rectilinear" design configuration was stopped in December 1984. An alternate "sawtooth" design is currently being developed. In our opinion, this condition results principally from difficulties experienced by DM&S in coordinating the views of Central Office program and field officials having an interest in the development of an NHCU prototype design. DM&S representatives acknowledge the weakness in the decision-making process and attribute this to the Agency's failure to establish a structure to handle the prototype development. As a result, VA is proceeding to construct NHCUs without an accepted prototype design. Consequently, architect costs incurred in developing an initial design will not result in a useable product; some of the cost advantages developed by the Nursing Home Cost Reduction Task Force have been negated; and projected savings resulting from the development and use of a computer-aided design and drafting system have been delayed or lost. However, we found no indication of obfuscation, denial, or fabrication of data within the Agency in the prototype design process.

c. Scope of Review: The audit was limited to a review of expressed allegations concerning the nursing home prototype project. We analyzed data and verified records obtained from the O/C and DM&S as were considered necessary during the audit. The audit was made in accordance with generally accepted government auditing standards.

2. RESULTS OF AUDIT

a. Expressed Concerns

(1) Resolution of Deviations From Uniform Federal Accessibility Standards Is Needed

The VA has not developed the prototype NHCU through the mechanical and structural design phases; therefore, concerns regarding the Uniform Federal Accessibility Standards (UFAS) may be premature. O/C and DM&S representatives acknowledge that the current architectural design does not meet UFAS requirements; however, they advise that the deviations will either be successfully appealed or that appropriate corrections will be made. The issue of whether or not the VA is required to be in full compliance with UFAS has been informally discussed with the Office of General Counsel, but the Counsel advises that they have not received a formal request for a legal opinion. O/C has expressed concern that currently planned construction might be found to be in violation. As a result, renovation and redesign of facilities currently under construction may be required if the issue is not resolved. In the opinion of O/C and DM&S, UFAS does not have universal applicability to VA facilities owing to VA patient mix.

(2) Features of Prototype Design Flexibility and Site Coverage Have Not Been Fully Defined

The concept of a prototype NHCU is based on the development of a design that can be used in multiple locations with minimum changes made for building site conditions. The two prototype designs considered by DM&S and O/C both use a cruciform structure. The basic building block of both designs is modular bedrooms off a core service area. Flexibility exists to some degree in each design by ease of change in placement of the modular units within the building. The original design called for a standard rectangular shaped bedroom module. The "sawtooth" design does require a larger building site. The design is 25 percent (23 to 24 feet) longer and provides for odd-shaped bedrooms in order to meet DM&S program requirements for a window in close proximity to each NHCU bed. Discussions with DM&S and O/C staff indicate that there were a number of patient care and staff operational efficiency considerations underlying the current preference for the "sawtooth" design. Some of the operational efficiency issues considered included length of corridors and staff travel distances, in-room patient visibility from nursing stations and hallways, and location of supply and service areas. These and other considerations had not been brought together into a decision package to identify and enable an evaluation of their relative advantages.

(3) Mechanical and Structural Design Problems Need to Be Resolved

Concerns regarding mechanical and structural deficiencies are based on a study of preliminary design drawings for the "sawtooth" prototype and the Prescott, Arizona NHCU, which is currently under design ~~and construction.~~ Neither set of drawings contain final details of mechanical and structural design layouts. Preliminary mechanical and structural layouts for the Prescott NHCU were overlayed on the "sawtooth" prototype design to identify potential deficiencies. This resulted in the identification of handicapped accessibility issues. O/C and DM&S agree that such a study raises valid points; however, they advise that the accessibility problems will be worked out as the design moves through the approval process.

b. Other Substantive Issues

(1) DM&S Prototype Review and Approval Process Is Inadequate

DM&S' approval of the initial "rectilinear" and the successor "sawtooth" prototypes were not supported by complete decision packages. Our review of documents and interviews with both DM&S and O/C program staff indicated that the DM&S review process was informal and did not result in an assessment of pertinent potential problems and alternatives. For instance, DM&S program staff considered various NHCU bedroom sizes in early 1983 and had hired a consultant to develop design alternatives. While our review of various documents indicates that DM&S finally settled on the 235-square-foot module, there is no record as to how the decision was reached. The importance of this issue (the bedroom design) is raised throughout the development of the prototype designs. While DM&S approved the "rectilinear" prototype in October 1983, the CMD's Advisory Committee raised concerns with the design and ultimately recommended changes that resulted in the "sawtooth" design. O/C had earlier considered the "sawtooth" design and dismissed it in March 1983 as too expensive. Other issues of concern were also raised during the approval process relating to space utilization, patient privacy, and support activities. While there was ultimately a design selection, there was no evidence of consideration of alternatives. The nearest document to a consolidated decision package was an architectural drawing dated October 1983 bearing the signatures of DM&S Central

4.

Administrator (00)

Office program officials. However, even this proved to be incomplete as there was no evidence of field input. DM&S has not established a formal approval process, documented consideration of alternatives, and prepared a package from which an informed decision can be made.

(2) DM&S Design Selection Has Negated Anticipated Cost Advantages

The late selection of the "sawtooth" prototype design has resulted in the delay of an Architect/Engineer contract for working drawing design and development of a Computer-Aided Design and Drafting (CADD) system and delays in anticipated cost savings resulting from the use of a prototype. O/C estimates indicate that the "sawtooth" design will cost approximately $172,000 more for a 60-bed unit and $343,000 more for a 120-bed unit than the "rectilinear" design. These estimates were based on increases in gross square feet and may not adequately consider the additional cost for the more complex, "sawtooth" design. In addition, due to the timing (November 1984) of DM&S' decision to change the prototype design, O/C had to stop work on a $1,000,000 contract, started in July 1984, for the development of the "rectilinear" prototype working drawings and a CADD system. O/C stopped the contractor's work on the prototype design in December 1984 and on the CADD system in June 1985. To date, the contractor has been paid approximately $615,000. As a result of these actions, the VA may have to request additional funds for design work until a prototype is selected. Estimated cost savings of $379,000 per NHCU project will not be realized until the CADD system design has been completed.

(3) Accommodation of Spinal Cord Injury Patients

Responding to a concern raised in early 1984, VA agreed to defer approval of the NHCU prototype design until accommodations were made to assure that spinal cord injury patients could be treated in the units. Present unresolved issues concerning federal accessibility standards, mechanical and structural design problems, and broad prototype design changes have heightened concerns that the prototype units may not now accommodate wheelchair or spinal cord injury patients. DM&S and O/C program staff advise that VA remains committed to providing bedroom unit modules that will accommodate spinal cord injury patients and wheelchair access to all patients.

3. AUDIT CONCLUSIONS AND RECOMMENDATIONS

In our opinion, the expressed primary concern regarding the absence of an acceptable prototype NHCU design is valid. The absence of an accepted design has led to related concerns that turn on the absence of working drawings. The VA should establish an appropriate design and approval process for assuring a cost-effective design of prototype nursing homes. Once a final decision has been proposed, it should be discussed with appropriate interested parties.

4. MANAGEMENT COMMENTS

The results of our review were discussed with representatives of DM&S and O/C. Their comments did not indicate substantial disagreement with our findings, however, they felt that circumstances surrounding the development of the prototype were unique. The Agency did not have *in place nor did it* establish on *an ad hoc* basis a structure to manage the project. It was their view that the planned reorganization of O/C and DM&S will correct organizational issues leading to problems surfaced in this review.

5. OIG COMMENTS

In our opinion, the planned reorganization of O/C and DM&S will not ensure resolution of the issues related to the NHCU prototype. Specific responsibility, authority, and milestone targets are needed to initiate a comprehensive decision package to the Administrator for review and approval.

Frank S Sato

FRANK S. SATO

EXECUTIVE SUMMARY

This executive summary provides an overview of three reports to the Veterans Administration (VA) that document, evaluate, and recommend improvements to the Health Care Facility (HCF) Construction Process. It is the final report in the Comprehensive Study of the VA's Organization and Procedures for Constructing Health Care Facilities.

1. THE PURPOSE OF THIS STUDY IS TO EVALUATE AND RECOMMEND IMPROVEMENTS TO THE VA's HCF CONSTRUCTION PROCESS

The purpose of the study is to assess the organization and procedures used by the VA to construct health care facilities. It was initiated as a result of several factors, probably the most important of which was the VA's recognition that the need for new facilities is increasing and will continue to increase with the greying of the veteran population and the aging of the current HCF inventory. Because the HCF Construction Process is critical to meeting this need and, hence, to the ability of the VA to carry out its mission, the VA felt that a study of the efficiency and effectiveness of the process was necessary.

A second purpose of the study is to look at criticisms that have been aimed at the process itself. Increases in construction activity have already begun to strain available construction resources. As a result, the current process has been criticized both from within and outside the VA for being costly, lengthy, and inflexible. The VA felt that a study was needed to determine the underlying causes of these criticisms and to develop alternatives for resolving them.

Booz, Allen & Hamilton Inc. and RTKL Associates Inc. conducted the overall study of the HCF Construction Process to address these objectives. As stated by the VA, the study has three goals:

- To determine, consistent with the health care mission of the VA, the most effective and efficient internal organizational and procedural structures for defining, developing, designing, constructing, maintaining, and improving medical and health care related capital facilities of high quality, consistent with resource and timeliness considerations
- To assist the VA in evaluating the appropriateness, effectiveness, and efficiency of its current organizational and procedural structures for the functions described above
- To implement, if appropriate, innovative, practical alternatives to the VA's current organization and procedures for delivering HCF construction programs by means of fully supported recommendations for change.

The study has been carried out in three phases, with a study report developed at the completion of each phase:

- Phase I, Process Documentation - Presented detailed data gathered through interviews and a review of existing documents; described the organization, information and communication flows, program planning linkages, and process controls of the HCF Construction Process
- Phase II, Data Evaluation and Analysis - Presented the results of 11 process analyses and 24 summary problem statements defining weaknesses in the HCF Construction Process
- Phase III, Proposals and Recommendations - Presented recommendations for improving construction policies and procedures and the organization for carrying out the HCF Construction Process.

This executive summary provides an overview of the previous study reports and is the Phase IV Final Report.

2. THE DEPARTMENT OF MEDICINE AND SURGERY (DM&S) AND THE OFFICE OF CONSTRUCTION (O/C) SHARE RESPONSIBILITY FOR PLANNING, DESIGNING, AND CONSTRUCTING HEALTH CARE FACILITIES

The purpose of the HCF Construction Process is to translate defined health care facility construction needs into in-place construction. It requires a significant level of funding, close to $750 million in FY84, and the efforts of staff in four major organizations in the VA: the Office of the Administrator, DM&S, O/C and VA Medical Centers (VAMC).

Construction needs are addressed in the HCF Construction Process through the planning and execution of construction projects. Procedures used and responsibilities assigned depend on the type of construction project or need addressed. The four types of construction projects are as follows:

- Major Construction - Projects with an estimated cost of $2 million or more
- Minor Construction - Projects with an estimated cost of between $400,000 and $2 million
- Minor Miscellaneous Construction - Projects with an estimated cost of between $100,000 and $400,000
- Nonrecurring Repair and Maintenance (NRM) - Projects for nonrecurring maintenance work or repair, replacement of or additions to building service equipment, and/or minor improvements where the minor improvement portion of the project is between $15,000 and $100,000.

This section briefly describes procedures and responsibilities for carrying out these projects, as documented in Phase I of the study.

(1) Policies and Procedures Followed in the HCF Construction Process Directly or Indirectly Support Project Planning, Design, and Construction Activities

Most activities of the HCF Construction Process focus on the management and execution of three construction project phases:

- Project planning - During which design requirements are developed for identified construction needs
- Design - During which project plans are translated into construction documents
- Construction - During which construction documents are executed to produce in-place construction.

Project planning, although performed for all types of construction, is a formal process phase only for Major and Minor Construction projects. Project planning is generally a two-step process. The initial step, development of a data package, requires the collection of VAMC workload and staffing projections. This information is then used to carry out the second step, development of a space program. The space program, developed by applying data package projections to space planning criteria, provides information required to define project design requirements.

Project design generally consists of three distinct activities:

- During concept development, the project scope is generally defined and a conceptual approach to design is selected
- During preliminary plans development, architectural, site, and engineering plans are prepared to define the design solution
- During working drawings development, a complete graphic and narrative representation of the project is prepared.

Design activities result in a set of construction documents of sufficient detail to permit execution of the project in precise form, size, and materials.

The final phase--construction--consists of the "brick and mortar" activities required to execute design documents. During this phase, detailed shop drawings and material submissions are developed and approved and actual construction takes place.

Other support activities are required to manage and execute these phases of the process. Some of those activities, such as standards development and procurement and contracting, directly support execution of HCF Construction Process activities. Others, such as program budgeting and development of managment information, support the management of the HCF Construction Process.

Exhibit 1 illustrates the current process, showing relationships among activities and average execution time required. The duration of the phases varies by project type. For activities beginning with project planning and ending with design, for example, the process requires an average of 2 years for small NRM projects and 8 years for Major Construction projects.

(2) Responsibilities for Managing and Executing the HCF Construction Process Are Assigned to Four Major Organizations in the VA

The completion of construction projects through the HCF Construction Process requires the accomplishment of four process functions:

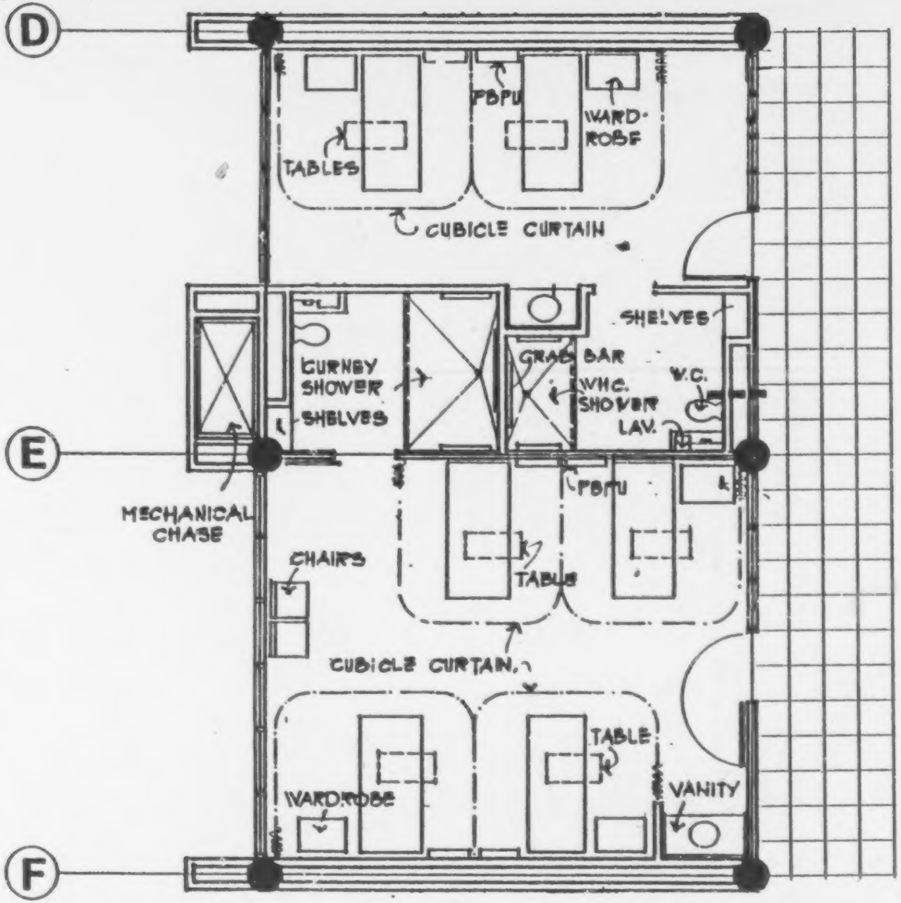
- Planning, which includes responsibility for identifying and defining construction program and project requirements
- Control, which includes responsibility for monitoring and evaluating project and process performance
- Execution, which includes responsibility for designing and constructing facilities
- Support, which includes responsibility for standards, procurement and contracting, management information, and other functions required to carry out the HCF Construction Process.

These responsibilities are assigned to four organizations in the VA: Office of the Administrator, O/C, DM&S Central Office, and VAMCs.

The Office of the Administrator is responsible for process oversight--one type of process control. Within this office, General Counsel is responsible for legal oversight and is involved generally in review of contract documents and claims. The Controller's Office is responsible for budget and fiscal oversight and is involved in all phases of the process. The Office of Program Planning and Evaluation is generally involved in the construction process during overall agency program planning and budgeting activities.

The Office of Construction (O/C) is involved in all phases of the construction process, and has a role in both management and execution. This office is responsible for:

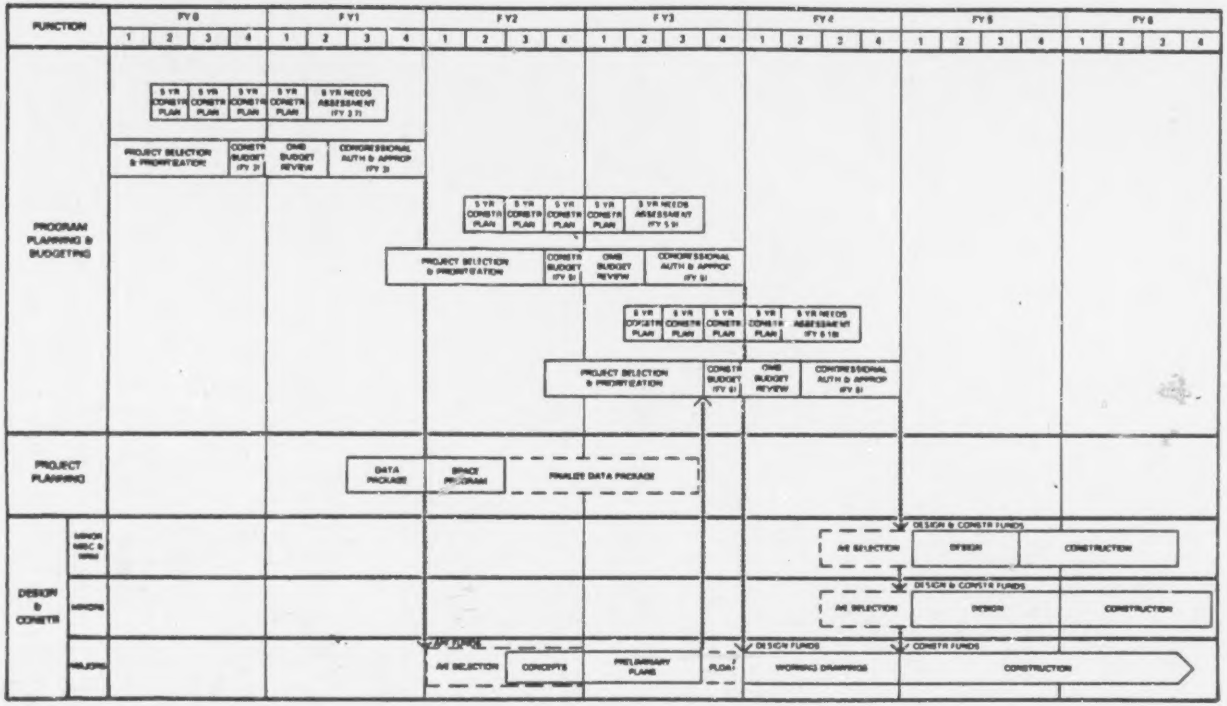
- Developing program and project plans
- Developing concepts for Major Construction projects and preliminary plans and working drawings for a small number of Major and Minor Construction projects
- Performing project and process control responsibilities for Major and Minor Construction


D
E
F
FBPU
WARD-ROBE
TABLES
CUBICLE CURTAIN
SHELVES
GURNEY SHOWER
SHELVES
GRAB BAR
WHC. SHOWER
W.C.
LAV.
MECHANICAL CHASE
FBPU
CHAIRS
TABLE
CUBICLE CURTAIN
TABLE
WARDROBE
VANITY

2 Bedroom
w/ wheelchair shower

4 Bedroom
w/ gurney shower

EXHIBIT I
OVERVIEW OF CURRENT HCF CONSTRUCTION PROCESS


FUNCTION
FY 0
FY 1
FY 2
FY 3
FY 4
FY 5
FY 6
1
2
3
4
PROGRAM PLANNING & BUDGETING
5 YR CONSTR PLAN
5 YR NEEDS ASSESSMENT (FY 3-7)
PROJECT SELECTION & PRIORITIZATION
CONSTR BUDGET (FY 3)
OMB BUDGET REVIEW
CONGRESSIONAL AUTH & APPROP (FY 3)
5 YR NEEDS ASSESSMENT (FY 5-9)
CONSTR BUDGET (FY 5)
CONGRESSIONAL AUTH & APPROP (FY 5)
5 YR NEEDS ASSESSMENT (FY 6-10)
CONSTR BUDGET (FY 6)
CONGRESSIONAL AUTH & APPROP (FY 6)
PROJECT PLANNING
DATA PACKAGE
SPACE PROGRAM
FINALIZE DATA PACKAGE
DESIGN & CONSTR
MINOR MISC & NRM
MINORS
MAJORS
DESIGN & CONSTR FUNDS
A/E SELECTION
DESIGN
CONSTRUCTION
A/E FUNDS 1
CONCEPTS
PRELIMINARY PLANS
FLOAT 2
DESIGN FUNDS
CONSTR FUNDS
WORKING DRAWINGS

1 ASSUMES USE OF DESIGN FUND FOR MAJOR CONSTRUCTION PROJECTS

2 "FLOAT" INDICATES SLACK TIME AVAILABLE TO COMPLETE PRELIMINARY PLANS BEYOND THE AMOUNT OF TIME TYPICALLY PLANNED BEFORE WORKING DRAWINGS ARE DELAYED.

- Developing standards and management information and procuring and contracting
- Executing on site construction projects.

During FY84, approximately 750 full-time equivalent (FTE) personnel in O/C were devoted to these functions.

Compared with this level of effort, the DM&S Central Office--specifically, the Office of Engineering, Planning, and Construction (FEPAC), plays a smaller role in the HCF Construction Process. Within FEPAC, staff are responsible for program and project planning and process control for all types of construction projects. During FY84, approximately 75 FTEs in FEPAC were devoted to these functions.

The fourth major organization involved in the HCF Construction Process is the DM&S field organization, specifically VAMCs. Much of the VAMC effort in the process is involved in managing and, in some cases, executing Minor Construction and NRM projects. VAMCs have also been increasingly assigned project management responsibility for Major Construction projects. Together with responsibilities for construction planning (e.g., development of 5-Year Facility Construction Plans and data packages), these functions required approximately 800 FTEs during FY84.

Exhibit 2 illustrates key responsibilities and relationships of elements in these four organizations.

3. ANALYSES OF THE HCF CONSTRUCTION PROCESS REVEALED PROBLEMS IN INTEGRATION OF THE CONSTRUCTION AND MEDICAL CARE PROGRAMS

Detailed analyses were conducted during Phase II of this study to identify areas where improvements could be made in the HCF Construction Process. The analyses identified weaknesses in policies, procedures, and organizational responsibilities that result in poor coordination between the construction and medical care programs. Program coordination requirements and problems are described below.

(1) Health Care Program and Health Care Resource Management Must Be Highly Integrated for the VA To Accomplish Its Mission

The effective use of resources in delivering health care services is a key determinant of overall VA effectiveness. While effective management of staff resources is perhaps most critical, effective management of facilities, equipment, and supplies is also of major importance. Planning for these resources, execution of the plans, and control over the use of resources are required for the effective delivery of health care services.

Effective coordination or integration between program management and resource management is essential in carrying out any program, but it is critical to effective health care delivery within the VA. Its importance can be attributed to three factors:

- The complexities involved in providing health care services, and the rapidly emerging changes in health care technology and the way services are provided. Improving medical service technologies and delivery modalities at the VAMCs require a construction process that is flexible and responsive to changing medical needs

- The special requirements for providing services in a federal government environment, where rigidities are built into many of the mechanisms required to obtain and utilize resources. Relatively long lead times required for obtaining federal construction resources and for obtaining A/E and construction contractor services require close working relationships between staff in the two programs throughout the early stages of the HCF Construction Process

- The characteristics of the population served by the VA--America's veterans--a population whose needs are changing as it grows older. As veterans gravitate toward more southern states, program strategies must change, and construction resources must be targeted as much as 10 years in advance of actual need in the health care program.

As with other types of resource management programs, health care facility construction must be closely integrated with health care program management to be effective in providing the resources to accomplish the VA mission.

(2) Weaknesses in Construction Policies and Procedures Limit the Effectiveness of Integration Between Health Care Facility Construction Management and Health Care Program Management

The coordination of health care facility construction initiatives with health care program management initiatives is hindered by three weaknesses in present construction policies and procedures:

- Unsystematic and poorly coordinated facility construction planning

- A lack of useful health care facility planning standards

- An absence of effective tools for managing performance in carrying out health care facility plans.

In the current HCF Construction Process, construction planning tends to focus on individual project needs rather than on more strategic facility development needs. This approach does not provide an adequate foundation for carrying out long-term planning. The result is inefficient utilization of resources, poorly coordinated construction activities at individual facilities, and ineffective project planning.

Another problem with the current approach to construction planning is that it fails to provide a mechanism for systematically addressing future facility needs. Through the current Medical District Initiated Planning Process (MEDIPP), long-range medical program needs are identified for the national health care program and programs at individual VAMCs, but implementation of those program directions is not well coordinated. Consistency of approaches, resulting from a definition first of strategic facility development requirements, is critical to effective coordination between the two processes.

Coordination at the individual construction project level is also hindered by facility planning standards that do not accurately reflect medical operating modalities. Standards have been developed, but a lack of explicitly defined assumptions about medical operating modalities, lack of definition within DM&S about medical operating modalities, and lack of agreement on operating modalities that have been developed, limit the usefulness of the standards as a starting point in facility planning. When facility planners attempt to adhere strictly to those standards, the result is facilities that do not meet the true needs of those who must provide services.

The lack of effective control tools for monitoring and evaluating performance results in construction delivery timeframes that are generally regarded as unacceptable by those involved in the HCF Construction Process. The effectiveness of the process in implementing health care program directions suffers.

(3) Coordination Is Hindered by the Placement of Oversight Responsibilities in the Office of Construction

One of the major findings of the Phase II data evaluation and analysis was the problem of excessive fragmentation of responsibilities for HCF Construction Process management. The analysis found that DM&S and O/C share responsibility for a number of management functions, including:

- Developing project plans for Major and Minor Construction projects
- Selecting and funding (program planning) Major and Minor Construction projects
- Monitoring and evaluating process performance in carrying out plans.

This fragmentation of process management functions has been purposely fostered in the current process to provide a check on DM&S in defining facility construction requirements and in carrying out projects to meet those requirements. O/C, in addition to its responsibility for supporting DM&S in performing these functions, is also responsible for "policing" them. Because O/C's capabilities are required by DM&S to carry out construction projects and because, through that involvement, O/C can ensure that requirements are not overstated, this structure does provide an effective check on the process.

The cost, however, is enormous. The performance of oversight and support functions in one organization is not compatible and results in conflicts among staff in O/C and between staff in DM&S and O/C in carrying out the process. The placement of oversight responsibility in O/C results in confusion over who is actually responsible for managing the process, a duplication of DM&S management control responsibilities, and a lack of clear accountability. In addition to poor performance in carrying out the HCF Construction Process, this organization creates tensions and conflict that result in poor coordination with the health care program.

The Phase II analysis demonstrated the importance of integration between the HCF Construction Process and the health care program. It also identified characteristics of current construction policies and procedures and organizational responsibilities that hinder integration. Phase III identified specific proposals and recommendations for changes to increase integration between health care construction and health care program management.

4. RECOMMENDATIONS MADE IN THIS STUDY REPRESENT A MAJOR STEP TOWARD BETTER INTEGRATION BETWEEN THE HEALTH CARE PROGRAM AND THE HCF CONSTRUCTION PROGRAM

Improving the current level of integration between the construction program and the health care program requires adjustments in the HCF Construction Process in two general areas:

- Construction policies and procedures that provide greater consistency with the health care program
- Organizational functional alignments that reduce coordination requirements between the two processes.

Phase III recommendations addressed improvements in both areas.

Two sets of recommendations have been developed. The first set addresses improvements in policies and procedures, which together comprise the core process. These recommendations include:

- Implementation of a facility development approach to construction planning that provides a strategic framework for identifying individual construction projects within a VAMC
- Development of earlier, more comprehensive project scope descriptions that provide necessary information for initiation of 5-year facility construction planning and project design activities
- Integration of the 5-year facility construction planning process with the MEDIPP to allow more effective construction planning within the context of health care program directions
- Establishment of better national office construction planning information that focuses attention on the achievement of health care facility construction goals and objectives

- Redefinition of design activities to stress the logical progression of design decisionmaking from the resolution of functional design issues to the resolution of technical design issues
- Development of funding strategies that minimize coordination requirements between the construction and budget processes to allow uninterrupted project design
- Development of facility design standards and control techniques that provide the necessary tools for project planning and overall process control.

These recommendations, if implemented, will provide the consistency required between construction program and health care program policies and procedures to achieve effective integration.

The second set of recommendations, which addresses the organization of responsibilities for carrying out the HCF Construction Process, includes:

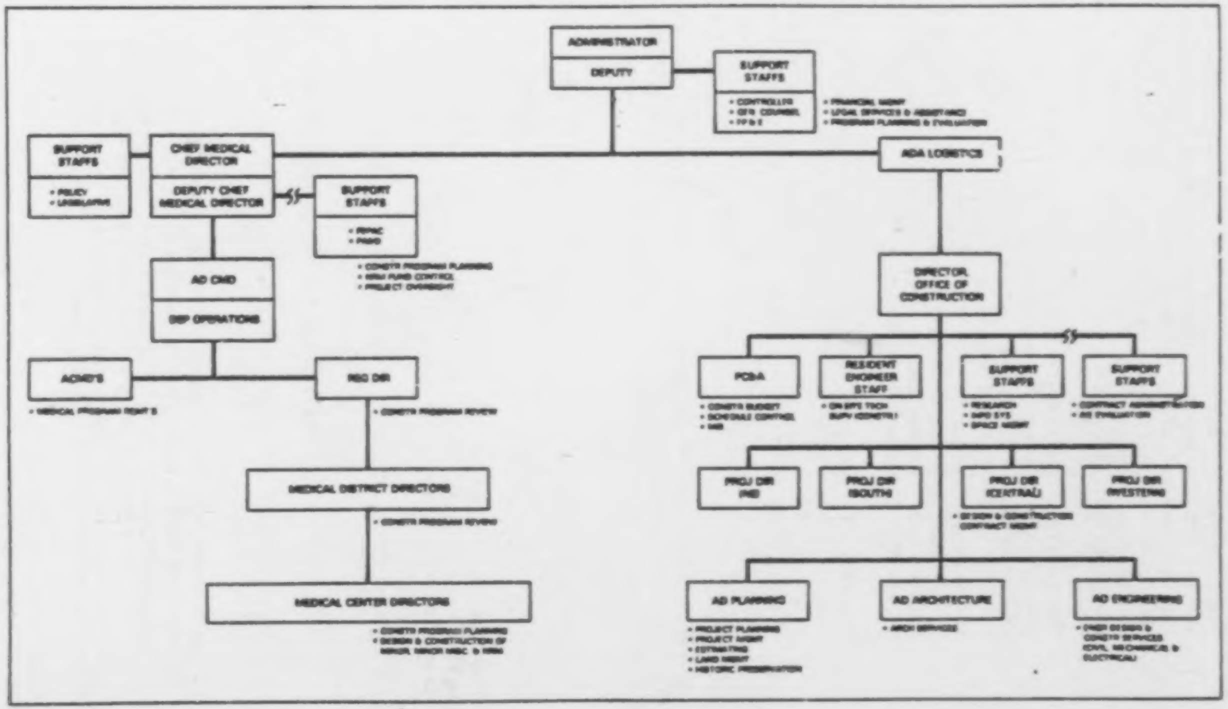
- Consolidation of all planning functions currently performed by both O/C and DM&S into DM&S to increase accountability for establishing construction requirements
- Realignment of project control, process control, and process oversight responsibilities as follows:
  - Consolidation of project control responsibility at the VAMC level during project planning and during design and construction for Minor Construction/NRM projects; consolidation of project control responsibility in O/C during design and construction for Major Construction projects
  - Consolidation of all process control responsibility in DM&S
  - Consolidation of all process oversight responsibility in the Controller's Office
- Maintenance of O/C general responsibility for executing Major Construction projects and of VAMC exclusive responsibility for executing Minor Construction and NRM projects, with delegation of responsibility for Major Construction projects to VAMCs only on a case-by-case basis
- Consolidation of responsibility for functional standards (e.g., space criteria) and management information development in DM&S; consolidation of responsibility for technical (i.e., building system) standards development in O/C.

This organization establishes DM&S Central Office as the manager of the HCF Construction Process, O/C as the provider of technical support and Major Construction design and construction manager; and VAMCs as project planners and managers for Minor Construction/NRM projects.

* * * * *

While representing a major step toward full integration between the health care program and the construction program, recommendations made in this study stop short of full integration. They do so in recognition of the major change in focus that would be required to integrate the two programs. Moving too far, too fast, may result in serious disruptions of both programs, especially during a period when other reorganizations are taking place within DM&S. Full integration without necessary oversight mechanisms (now provided, in part, by O/C) could affect program integrity. The recommendations made in this report provide a major step forward that, if implemented, will establish the necessary foundation for full integration between the health care and construction programs. We recommend that the VA adopt, as its long-term goal, the development of a fully integrated HCF Construction Process.

EXHIBIT 2
CURRENT CONSTRUCTION PROCESS ORGANIZATIONAL STRUCTURE


ADMINISTRATOR
DEPUTY
SUPPORT STAFFS
• CONTROLLER
• GEN. COUNSEL
• PP & E
• FINANCIAL MGMT
• LEGAL SERVICES & ASSISTANCE
• PROGRAM PLANNING & EVALUATION
SUPPORT STAFFS
• POLICY
• LEGISLATIVE
CHIEF MEDICAL DIRECTOR
DEPUTY CHIEF MEDICAL DIRECTOR
SUPPORT STAFFS
• RPPAC
• PABO
• CONSTR PROGRAM PLANNING
• MRM FUND CONTROL
• PROJECT OVERSIGHT
ADA LOGISTICS
AD CMD
DEP OPERATIONS
ACMD'S
• MEDICAL PROGRAM REQMT'S
REG DIR
• CONSTR PROGRAM REVIEW
MEDICAL DISTRICT DIRECTORS
• CONSTR PROGRAM REVIEW
MEDICAL CENTER DIRECTORS
• CONSTR PROGRAM PLANNING
• DESIGN & CONSTRUCTION OF MINOR, MINOR MISC. & NRM
DIRECTOR, OFFICE OF CONSTRUCTION
PCBA
• CONSTR BUDGET
• SCHEDULE CONTROL
• MIS
RESIDENT ENGINEER STAFF
• ON SITE TECH SUPV (CONSTR)
SUPPORT STAFFS
• RESEARCH
• INFO SYS
• SPACE MGMT
SUPPORT STAFFS
• CONTRACT ADMINISTRATION
• AE EVALUATION
PROJ DIR (NE)
PROJ DIR (SOUTH)
PROJ DIR (CENTRAL)
• DESIGN & CONSTRUCTION CONTRACT MGMT
PROJ DIR (WESTERN)
AD PLANNING
• PROJECT PLANNING
• PROJECT MGMT
• ESTIMATING
• LAND MGMT
• HISTORIC PRESERVATION
AD ARCHITECTURE
• ARCH SERVICES
AD ENGINEERING
• CHIEF DESIGN & CONSTR SERVICES (CIVIL, MECHANICAL & ELECTRICAL)

PART I - PROGRAM OPERATING PLAN
SECTION A - FORMAT I
PROGRAM GOALS, OBJECTIVES, PLANNED ACTIONS
OFFICE OF FACILITIES

I. Program Goals: The Office of Facilities is responsible for the timely, efficient and cost effective management of the VA's integrated capital facilities program, including The Facility Development Planning (FDP) Process; project planning, design and construction; real property and workspace management; and facility and land acquisition and disposal for all VA Departments and Staff Offices.

II. Program Objectives and Indicators: Implement Facility Development Planning Process (BAH/RTKL Core Process Recommendation #1).

A. Program Objectives: 1. To develop and maintain a comprehensive, integrated, nationwide assessment of VA medical centers' technical and functional facility needs through implementing an overall Facility Development Planning Process in order to improve facility planning, budget resource allocation and project prioritization.

B. Program Indicators: In FY 1987, pilot test FDP process at selected VA medical centers, refine FDP statement of task and contract for approximately forty FDPs.

III. Explanation of Program Objectives and Indicators:

The Booz, Allen & Hamilton/RTKL study of the VA's organization and procedures for constructing health care facilities recommended as one of its seven "core process recommendations" that the VA implement an overall facility development approach to construction. In support of this initiative the VA received its first funding in FY 1987 to undertake approximately forty Facility Development Plans (FDPs) in FY 1987. An FDP is a written, comprehensive, integrated plan for the development of a VA medical center over a specific long-range planning horizon. The FDP, based on programmatic and operational needs, deficiencies and priorities, provides for each VA medical center functional and technical analyses, existing and required facility characteristics, alternative space allocation plans, facility development cost estimates, a selected facility development strategy and logical groupings of construction activities (Major, Minor, Minor Miscellaneous and NRM) to meet the strategy, needs and deficiencies identified, including those colocations, plans/needs, identified by DVB, DMA or General Counsel, if any. These projects will become the basis of the Facility's Five Year Plan as well as the agency's Five Year Medical Facility Development Plan and construction budget request. Pilot testing of FDPs and initiation of the first forty FDPs in FY 1987 will implement the first phase of this facility planning improvement initiative. Completion of all FDPs is scheduled for FY 1989.

IV. Planned Actions and Schedules with Milestones

	Description of Planned Action/ Milestone	Planned Starting Date Month/Year	Planned Completion Month/Year
Planned Action 1	Initiate first 40 FDPs in FY 87.	10/86	3/88
Milestone 1	Request APP funds in FY 87 to initiate first 40 FDPs.	2/86	10/86
Milestone 2	Organizational realignment - Office of Facilities (Grace Commission recommendation).	7/86	10/86
Milestone 3	Pilot test Facility Development Planning Process at selected VA medical centers.	6/86	6/87
Milestone 4	Commence contracting for FY 87 FDPs based on feedback from pilot studies.	7/87	9/87
Planned Action 2	Request FY 88 APP funds to undertake an additional 40 FDPs in FY 88.	9/86	10/87
Planned Action 3	Request FY 89 APP funds to complete FDPs for all VAMCs.	9/87	10/88
Planned Action 4	Develop integrated VA-wide Facility Development Data Base to enhance planning and FDP update capabilities.	6/87	Continuous
Planned Action 5	Develop FDP update methodology, performance indicators to judge effectiveness of FDP process; and procedures for effective use of FDPs in development of construction planning documents and budgets.	7/87	3/88

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II. Program Objectives and Indicators: Improve project definition (BAH/RTKL Core Process Recommendation #2).

A. Program Objectives: 2. To develop an earlier and better definition of design problems, constraints, and requirements.

B. Program Indicators: Completion of FDPs, fewer changes in scope and post occupancy evaluation feedback.

III. Explanation of Program Objectives and Indicators:

Project planning information is needed for both construction program planning and project design. When a project is first defined, information is needed to provide an adequate description of the project, justification data, assumptions used in developing a cost estimate, and a description of management requirements. The availability and use of additional and more reliable information would increase efficiency and user satisfaction and result in fewer recycles and changes.

IV. Planned Actions and Schedule with Milestones

	Description of Planned Action/ Milestone	Planned Starting Date Month/Year	Planned Completion Month/Year
Planned Action 1	Complete pilot and FY 87 FDPs, including initial design programming.	10/86	3/88
Planned Action 2	Projects generated from FDPs identified and prioritized for inclusion in 5 year needs assessment and APP lists.	To be determined	To be determined
Planned Action 3	Develop projects through completed preliminary plans (second phase design programming.)	To be determined	To be determined

PART I - PROGRAM OPERATING PLAN
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II. Program Objectives and Indicators: Better coordinate construction and medical program planning (#3 BAH/RTKL Core Process Recommendation).

A. Program Objectives: 3. To restructure construction planning process to bring it into closer coordination with medical program planning.

B. Program Indicators: Independent reviews (e.g. IG) support project justification; project scopes accurately reflect projected workload requirements.

III. Explanation of Program Objectives and Indicators:

The purpose of the VA facility construction program is to provide facilities necessary for the VA to carry out its mission. Frequently, however, facility and program planning are viewed and carried out independently of each other. Construction program planning should continuously be based and validated on program planning initiatives, data, and requirements.

IV. Planned Actions and Schedule with Milestones

	Description of Planned Action/ Milestone	Planned Starting Date Month/Year	Planned Completion Month/Year
Planned Action 1	Use most current MEDIPP and other medical program information to do FDPs (pilot and FY 87).	6/86	7/87

	Description of Planned Action/ Milestone	Planned Starting Date Month/Year	Planned Completion Month/Year
Planned Action 2	Annually validate completed PDPs against updated MEDIPP and other medical programming information.	7/87	Ongoing
Planned Action 3	Use updated MEDIPP data and validated PDPs in specific project planning.	7/87	Ongoing
Planned Action 4	Revalidate projects against MEDIPP at specific milestones: as project appears on APP list, at beginning of concepts, before doing prelims, and before doing working drawings.	7/87	Ongoing
Planned Action 5	FY 1988 - FY 1992 Five Year Medical Facility Development Plan - milestones and deliverables.	10/86	6/87

	Description of Planned Action/ Milestone	Planned Starting Date Month/Year	Planned Completion Month/Year
Milestone 1	Update prioritization data where necessary.	10/86	2/87
Milestone 2	Prepare submission, circulate for comments/ concurrence and make necessary revisions.	2/87	4/87
Milestone 3	Administrator's approval.	4/87	4/87
Milestone 4	OMB concurrence and transmittal to Congress.	5/87	6/87
Planned Action 6	Program data for proposed FY 1989 Major Construction Program - milestones and deliverables.	10/86	3/87
Milestone 1	Information request to the Office of Planning & Development.	10/86	1/87
Milestone 2	Information received from the Office of Planning & Development.	2/87	3/87

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II. Program Objectives and Indicators: Improved information for construction program resource allocation decisions (BAH/RTKL Core Process Recommendation #4).

A. Program Objectives: 4. To develop sufficient information on total system requirements and how individual projects meet the requirements.

B. Program Indicators: Program Data Bases

III. Explanation of Program Objectives and Indicators:

Within any program such as facility planning, design, and construction, there are limited resources available. In order to effectively allocate these resources, it is necessary to determine total system needs, prioritize those needs, and determine how individual projects fit into this framework.

IV. Planned Actions and Schedule with Milestones

	Description of Planned Action/ Milestone	Planned Starting Date Month/Year	Planned Completion Month/Year
Planned Action 1	Develop facility development planning data bases.	7/87	Ongoing
Planned Action 2	Use FDP data bases to determine overall system deficiencies.	To be determined	Ongoing
Planned Action 3	Reassess prioritization methodology vis a vis planning data bases, system deficiencies, and program requirements.	7/85	Ongoing

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II. Program Objectives and Indicators: Earlier resolution of functional and scope issues (BAH/RTKL Core Process Recommendation #5).

A. Program Objectives: 5. To structure design activities to resolve functional and scope issues earlier in the design process.

B. Program Indicators: Reduce change orders; less design recycling; better adherence to project schedules.

III. Explanation of Program Objectives and Indicators:

An efficient and effective design process requires a logical progression from approach definitions through architectural and engineering design. Currently initial planning is insufficient to resolve scope issues before design and changes in scope and functional requirements are allowed well into the development of the technical requirements of the design.

IV. Planned Actions and Schedule with Milestones

	Description of Planned Action/ Milestone	Planned Starting Date Month/Year	Planned Completion Month/Year
Planned Action 1	Scope and functional considerations identified in FDP.	6/86	Ongoing
Planned Action 2	Further development through second phase of design programming (i.e. through preliminary design).	To be determined	Ongoing

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II. Program Objectives and Indicators: Improve VA space planning criteria (BAH/RTKL Core Process Recommendation #7).

A. Program Objectives: 6. Review, revise, and develop improved functional design standards and criteria based on standardized operating modalities to be used as bases for project planning.

B. Program Indicators: Update criteria chapters and SCI design guideplates.

III. Explanation of Program Objectives and Indicators:

One of the problems currently experienced in VA's facility planning process is the length of time to develop projects and the changes that are requested after projects are planned. The development of standard criteria and standards is essential for improved efficiency and effectiveness.

IV. Planned Actions and Schedule with Milestones

	Description of Planned Action/ Milestone	Planned Starting Date Month/Year	Planned Completion Month/Year
Planned Action 1	Explicitly identify operating assumptions included in current space and functional systems and update standards that are obsolete.	1/87	Ongoing

United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

June 26, 1986

Honorable Robert Dole
Majority Leader
United States Senate
Washington, D. C. 20510

Dear Mr. Majority Leader:

Pursuant to section 5004(a) of title 38, United States Code, the Senate Committee on Veterans' Affairs has adopted the enclosed resolution by a vote of its members completed today, June 26, 1986. The resolution approves 12 medical facility construction projects, as well as advance planning funds, asbestos abatement, and design funds for various stations. In the listing attached to the resolution and incorporated by reference therein, the projects are identified and their estimated fiscal year 1987 costs are indicated.

We note that the projects which have been approved are those for which the Administration has requested approval and appropriations plus two nursing home care projects -- in Tampa, Florida, and Mountain Home, Tennessee. With respect to these and any future nursing home projects, the Committee expects that the VA will use its prototype nursing home design or, if not feasible, adapt modular components for the design and construction of the projects.

The Committee also intends that, in the future, the VA actively pursue the possibility of a build/lease, purchase, lease, or a sharing agreement for any proposed new or replacement hospital, nursing home, or domiciliary facility. The Committee expects the VA to investigate the availability of community nursing home care beds prior to requesting approval and appropriations for any new nursing home care projects.

Sincerely,

Alan Cranston

Frank H. Murkowski
Chairman

Alan Cranston
Ranking Minority Member

Enclosures
cc: Honorable G.V. "Sonny" Montgomery
Honorable John Paul Hammerschmidt
Honorable Mark O. Hatfield
Honorable John Stennis
Honorable Jake Garn
Honorable Patrick Leahy
Honorable Thomas K. Turnage

RESOLUTION OF THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

RESOLVED BY THE COMMITTEE ON VETERANS' AFFAIRS OF THE UNITED STATES SENATE, pursuant to section 5004(a) of title 38, United States Code, that the major medical construction projects specified in the attached listing are approved at the estimated costs shown.

Alan Cranston

FRANK H. MURKOWSKI
Chairman

ALAN CRANSTON
Ranking Minority Member

Adopted: June 26, 1986

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

AUG 7 1986

In Reply Refer To: 171B

Honorable Frank H. Murkowski
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The review of the Medical District Initiated Program Planning (MEDIPP) plans for 1985 has been completed, and the Department of Medicine and Surgery will now develop an Annual Implementation Plan based on approved proposals in this MEDIPP Plan.

Enclosure (1) is provided to explain in detail the significance of "MEDIPP approval." Briefly, a MEDIPP proposal can be approved at one of three levels. Level 1 approval means only that the need represented is recognized as legitimate; however, the proposal has not been developed sufficiently to be considered for implementation. Thus, proposals approved at Level 1 cannot yet be implemented. Level 2 approval means that implementation can be started, and the proposal can be included in an Annual Implementation Plan. Level 3 is reserved for proposals which must be included in the Agency Budget request for funding before they can be implemented. Level 3 approval, therefore, means that the proposal is appropriate for possible inclusion in an Agency Budget request.

The major issues have been divided into 6 categories and are discussed in enclosure (2) "1985 MEDIPP Status Report."

The MEDIPP process has emerged as a cornerstone in the VA's strategic management efforts over the past four years, and it has significantly enhanced the quality of decision-making on health care matters. The Agency is committed to building upon and refining this valuable planning tool and requests your continued support in these endeavors. Hopefully, the information provided herein will assist you in your oversight responsibilities.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosures

"America is #1—Thanks to our Veterans"

ENCLOSURE (1)

Three Levels of Medical District Initiated Program Planning (MEDIPP) Approval

Level One - Chief Medical Director and Administrator Concurrence with MEDIPP Needs Assessments

At the end of each annual MEDIPP planning cycle, the Chief Medical Director and Administrator are asked to concur in the medical district's assessments of program need for future actions, projects, and mission changes. The concurrence of the CMD and Administrator in these assessments signifies that the districts have adequately identified and validated certain future needs for new programs or changes in existing programs. The Chief Medical Director's and Administrator's concurrence with the district program needs assessments at this point in the planning process does not mean that all necessary planning for the proposed action has been accomplished, and it does not provide assurance that funds needed to support implementation of the action will be budgeted.

Level Two - Approval for Advanced MEDIPP Implementation Planning

After the Level One concurrence of the Chief Medical Director and Administrator, an action or project may require additional, detailed implementation planning (e.g. determination of a specific site for the project; detailed staffing requirements for the project). Items approved for advanced MEDIPP implementation planning will be included in an annual DM&S MEDIPP Implementation Plan. Implementation planning will be conducted prior to making final decisions to implement the action. The decision to implement the action is made by the Veterans Administration Department of Medicine and Surgery official who has the delegated authority to do so.

Level Three - Approval of MEDIPP Actions and Initiatives for Inclusion in the Administration's Budget Proposal

Certain MEDIPP actions cannot be implemented without the availability of additional appropriations. Therefore, these actions must be prioritized and submitted for possible inclusion in the Administration's budget proposal. Decisions as to which items are ultimately included are made through the routine, annual budget preparation process.

Note: Levels two and three do not necessarily occur in sequence. At times, implementation planning is completed prior to budget preparation. At other times, implementation planning begins or continues after the development of the budget (e.g. major construction projects).

ENCLOSURE (2)

1985 MEDIPP STATUS REPORT

Category	VAMC	Proposal	Approval Status
Convert Hospital beds to Nursing Home Beds.	Batavia, NY	Convert a total of 75 hospital beds to nursing home beds in accordance with plans to change mission to Extended Care.	Level 2 and Level 3 as necessary.
	Buffalo, NY	Convert 34 hospital beds to nursing home beds.	Level 2 and Level 3 as necessary.
	Pittsburgh, PA	Convert unused space to 60 nursing home care beds.	Level 2 and Level 3 as necessary.
	Chillicothe, OH	Convert unused space to 37 nursing home care beds.	Level 2 and Level 3 3 as necessary.
	Cleveland, OH	Convert 95 hospital beds to nursing home beds.	Level 2 and Level 3 as necessary.
	Sepulveda, CA	Convert 42 hospital beds to nursing home beds.	Level 2 and Level 3 as necessary.
Convert nursing home beds to domiciliary beds.	Butler, PA	Convert 41 nursing home beds to domiciliary beds to provide part of 200 identified domiciliary beds needed.	Level 2 and Level 3 as necessary.
Convert VA nursing home beds to community beds.	Biloxi, MS	Convert 35 VA nursing home beds to community beds as an interim solution to operating problems with existing beds.	Level 2 so that more more detailed implementation planning may be done.
	Fargo, ND	Convert 50 VA nursing home beds to community beds.	Level 1 so that further planning will be done before being considered for implementation.

Category	VAMC	Proposal	Approval Status
	West Los Angeles, CA	Convert 60 VA nursing home beds to community beds.	Level 1 so that further planning will be done before being considered for implementation.
Consolidate inpatient workload.	Tuscaloosa, AL	Eliminate 50 internal medicine beds at VAMC Tuscaloosa and transfer workload to VAMC Birmingham.	Level 1 so that further planning will be done to determine what type of bed is most appropriate for reduction before being considered for implementation.
	Miles City, MT	Change mission to predominantly Extended Care.	Level 1 so that further planning will be done before being considered for implementation. Consideration is currently being given to move this proposal to Level 2.
	Big Spring, TX	Change mission to predominantly Extended Care.	Level 1 so that further planning will be done before being considered for implementation.
	Prescott, AZ	Change mission to predominantly Extended Care.	Level 1 so that further planning will be done before being considered for implementation.
	Walla Walla, WA	Change mission to Outpatient Care.	Remanded to medical district for fu[illegible] study; results due back to VACO by September 5, 1986.
Consolidate outpatient workload.	Brooklyn, NY	Close Ryerson Street Satellite Outpatient Clinic and consolidate workload at parent VAMC.	Level 2 for implementation during 1987; Level 3 not necessary.
	Butler, PA	Relocate Youngstown Outpatient Clinic to parent VAMC.	Level 2 for implementation; Level 3 not necessary.

Category	VAMC	Proposal	Approval Status
New Outpatient Clinics	Dallas/Houston, TX	Establish Satellite Outpatient Clinic in either the Tyler or the Lufkin, TX area.	Level 3; specific site will be selected by Spring of 1987.
	East Orange, NJ	Establish Satellite Outpatient Clinic in the Ocean County, NJ area.	Level 3 for possible inclusion in the Agency's budget.

	Description of Planned Action/ Milestone	Planned Starting Date Month/Year	Planned Completion Month/Year
Planned Action 2	Define the way services are provided by VAMCs for functions that are available to standardize and identify major variations.	6/87	Ongoing
Planned Action 3	Develop room layout guides, identifying room dimensions and typical equipment layouts for rooms designed by VA.	5/86	To be determined
Milestone 1	SCI design guideplates.	3/86	To be determined
Planned Action 4	Update specific H-08-9 Chapters.	10/86	9/87
Milestone 1	Complete 15 criteria chapter revisions for DM&S (Laundry Criteria Chapter 408-IG/GAO recommendation).	10/86	9/87
Milestone 2	Complete new criteria chapters for DVB.	10/86	9/87
Milestone 3	Complete 2 criteria revisions for DMA.	10/86	9/87

VETERANS' ADMINISTRATION
MAJOR MEDICAL FACILITY CONSTRUCTION PROJECTS
(In thousands of dollars)

Location	Project Description	Prior Appropriation	Approved for FY 1987	Total Estimated Cost
Augusta (Uptown Division), GA	Replacement Medical Center	$ 12,400	$ 84,600	$ 97,000
Baltimore, MD	Replacement Medical Center	10,800	110,200	121,000
Dayton, OH	Bed Replacement Modernization	—	8,400	84,000
Milwaukee (Wood), WI	Fire and Safety Improvements	—	8,400	8,400
Mountain Home, TN	120 Bed Nursing Home Care Unit	—	6,500	6,500
North Chicago, IL	Environmental Improvements, Patient and Nursing Home Care Buildings	—	9,200	92,000
Salem, VA	Outpatient, Clinical and Nursing Unit Addition	—	66,300	66,300
Salisbury, NC	Geropsychiatric Building	—	19,000	19,000
Salt Lake City, UT	Electrical Distribution	—	6,600	6,600
Tampa, FL	120 Bed Nursing Home Care Unit	—	6,000	6,000
Waco, TX	Renovate Buildings 10 & 90	—	9,700	9,700
White River Junction, VT	Research and Education Building	—	9,300	9,300
Various Stations	Advance Planning Funds	—	5,000	5,000
Various Stations	Asbestos Abatement	—	9,908	9,908
Various Stations	Design Funds	—	19,000	19,000
Total, Major Construction		23,200	378,108	559,708

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

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Administration

JUL 2 5 1986

Honorable Frank H. Murkowski
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

On February 5, 1986, the Acting Administrator of Veterans Affairs submitted proposed legislation to waive the requirements of 38 U.S.C. section 210(b)(2) for an administrative reorganization within the Veterans Administration (VA) involving the transfer of the Office of Construction to the Department of Medicine and Surgery (DM&S). I know this proposed reorganization has been of considerable interest to you.

Since I was confirmed as Administrator of Veterans Affairs on March 24, 1986, one of my first priorities has been to thoroughly review this very significant reorganization proposal. To assist in this assessment, I have reviewed available information and documents related to the proposal, including the "Comprehensive Study of the Veterans Administration's Organization and Procedures for Constructing Health Care Facilities" (Booz, Allen & Hamilton, Inc./RTKL Associates, Inc.-April 1985), and drawn on the collective expertise of officials within the Department of Medicine and Surgery, the Office of Construction, and others.

Based on my review, I fully endorse the goals which the previous Administrator sought to achieve by his proposed reorganization, and I affirm my commitment to those same goals: to improve the effectiveness and efficiency of our construction and real property programs, and to eliminate duplicative and confusing fragmentation of responsibilities and accountability for these programs. Nevertheless, I have determined that it would be in the best interest of the Veterans Administration to withdraw that proposal. Concurrently, I also withdraw the Acting Administrator's request to waive the requirements of 38 U.S.C. section 210(b)(2) regarding the proposed reorganization.

I strongly believe that there must be a single organizational element within the VA which is fully responsible and accountable for the integrated management of the Agency's capital facilities and real property programs. I also fully support the previous conclusion that immediate establishment of that single source of accountability will facilitate the ability of the Administrator of Veterans Affairs to ensure achievement of the critical process improvements recommended in the Booz, Allen/RTKL study. However, my review also has convinced me that the overall needs of the VA will best be served if the Agency's capital facilities and real property programs are consolidated in an independent staff office function.

Consistent with the proposal presented to you last November, I, too, am firmly convinced that the Facilities Engineering, Planning and Construction (FEPAC) Office functions in DM&S and the Office of Construction must be consolidated into one unit to achieve a fully integrated capital facilities program. Accordingly, I have decided to transfer 64 of the 73 FEPAC FTEE ceiling from DM&S to the Office of Construction, along with appropriate supporting resources. As the current DM&S FTEE ceiling at Central Office is 664, the provisions of 38 U.S.C. section 210(b)(2) do not apply to this realignment. Effective July 31, 1986, therefore, I plan to detail the affected FEPAC elements of DM&S (64 FTEE) to the Office of Construction on an interim basis to facilitate the transition. On October 1, 1986, such elements will be permanently transferred. Corresponding amendments to our FY 1987 budget request will be submitted to you in the near future. The newly combined FEPAC and O/C offices will be renamed the Office of Facilities to better reflect its responsibilities for overall management of an integrated capital facilities program, including real property management, space management, overall facility planning, and project planning, design and construction activities. In FY 1987, the Office of Facilities will have a total FTEE ceiling of 734. This ceiling provides for an immediate reduction of 28 FTEE to reflect FY 1987 consolidation efficiencies over FY 1986 O/C and FEPAC levels (-54 FTEE if you use O/C's original Congressionally approved FY 1986 ceiling of 710). However, we will continue to assess the new organization to determine if further streamlining is possible.

I have enclosed for your review the decision memorandum which I issued today to the Agency which provides further details on this decision and my basis for it. In addition, a series of questions and answers on the realignment are provided which I hope you find helpful. The new alignment will achieve the same goals for the VA's construction program which the previous Administrator and I both share, but it avoids several disadvantages I perceived as inherent in the original proposal.

Members of the Committee staff were briefed on this issue by my Chief of Staff on July 17. I would be pleased to discuss my decision with you personally, and I look forward to our continued and mutual efforts to improve the VA's capital facilities program.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosures

Veterans
Administration

Memorandum

Date July 25, 1986

From Administrator (00)

Subj Organizational and Procedural Improvements in the VA's Construction Program

To Department Heads, Associate Deputy Administrators, Staff Office Directors, and all Field Stations

1. As you know, on October 31, 1985, my predecessor as Administrator of Veterans Affairs announced his intention to transfer the Office of Construction as a unit to the Department of Medicine and Surgery. This proposal was based in part on the findings and recommendations of the "Comprehensive Study of the Veterans Administration's Organization and Procedures for Constructing Health Care Facilities" (Booz, Allen & Hamilton/RTKL Associates-April 1985).

2. Since I was confirmed as Administrator, one of my first priorities has been to thoroughly review this very significant reorganization proposal. To assist in this assessment, I have reviewed available information and documents related to the proposed reorganization, including the Booz, Allen/RTKL study, and drawn on the collective expertise of officials within the Department of Medicine and Surgery, the Office of Construction, and others. My review is now completed, and this memorandum sets forth my decisions.

3. The Booz, Allen/RTKL study contains two primary findings. The first and most important finding is that the VA's current health care facility construction policies and procedures, principally in the area of program and project planning, need to be improved. Second, the VA's integration and coordination of its health care facilities construction program is hindered by the current fragmentation of responsibilities between the Department of Medicine and Surgery (DM&S) and the Office of Construction (O/C). The Booz, Allen/RTKL study further found that the VA's current health care facility construction process has a number of strengths which provide a good foundation upon which further improvements can be made. Based on my own observations, as well as my review of the program, I agree with these basic findings.

4. The VA's facility construction program, the second largest in the Federal Government, is critical to fulfilling the mission of this Agency to provide quality service on a timely basis to this nation's veterans. These facilities and real property holdings are capital investments which we improve and maintain to support the effective delivery of our services. To the extent that we can improve our management of these capital assets, we must take immediate action to do so and constantly assess our procedures and practices to strive for even better performance. Although the Booz, Allen/RTKL study only focused on one important part of the Agency's capital facilities program--the health care facility construction process--it contains a number of important

recommendations which I believe will be of benefit to our entire capital facilities program. In their assessment of our current program, the Booz, Allen/RTKL report, in particular, recommended many significant procedural improvements ("core process recommendations") which could be made in our current construction procedures. We need to immediately move forward in our implementation of these procedural efficiencies. Effective May 19, 1986, I assigned responsibility to the Associate Deputy Administrator for Logistics to develop an implementation plan for these core process recommendations and to integrate required actions into a plan for FY 1986 and the outyears. Through our implementation of these core process recommendations, I look forward to seeing measurable improvements in the procedures by which we plan, design and construct our capital improvements.

5. With respect to the organizational problems identified, the Booz, Allen/RTKL report offered three organizational options which would have transferred and consolidated various responsibilities within and between DM&S and O/C. During the Agency review of these options, there was unanimous agreement that the options should be taken further, and that health care and other (DVB, DMA) facility planning, design, construction and real property functions should be wholly integrated and consolidated in one organization. I agree with this assessment. Under the current organization, or indeed any organizational alignment which still divides responsibilities, it is extremely difficult to hold a specific organizational element responsible for performance. I, therefore, strongly believe that there must be a single organizational element fully responsible and accountable for all facility matters, including the integrated management of the VA's facilities planning, design, construction and real property programs. I also strongly believe that establishment now of that single point of accountability will facilitate my ability, as Administrator, to ensure achievement of the critical process improvements which must be made in our planning, design and construction of VA facilities.

6. My review, however, also has convinced me that the overall needs of the VA will best be served if the Agency's capital facilities and real property programs are consolidated in an independent staff office function. Placing the construction program within the Department of Medicine and Surgery, as previously proposed, raises several potential problems. First and foremost, the mission of DM&S is quality patient care, including an active program of medical education and research and medical backup to the Department of Defense. To potentially diminish in any way the Chief Medical Director's and the Department's ability to attend to this critical mission, particularly in this complex period in VA health care planning, would be most unfortunate. Similarly, the size,

complexity and resource requirements of the VA's construction program and real property holdings require significant management attention. Effective and efficient implementation of the improvements in these programs recommended in the Booz, Allen/RTKL study will add to these management responsibilities. To place these responsibilities on DM&S and the Chief Medical Director would divert attention away from the Department's primary health care mission and is not appropriate. Second, the VA's facilities program provides leasing, work space management, real property management, and planning, design and construction support to all three VA Departments and several VA staff offices. In the years ahead, I anticipate an active colocation program for DVB's regional offices, and continued expansion of our national cemeteries to meet our projected needs. These programs and their resource needs can best be supported by an independent facilities office whose primary mission is to serve the needs of all VA elements rather than to be a secondary mission of one of the VA's Departments. Finally, there is the issue of program oversight. Retention of an independent facilities office directly responsible and accountable for the sole function of meeting the capital facilities and real property needs of all elements of this Agency preserves and maintains critically needed program oversight and control of these programs more than any other organizational alternative. On the other hand, from a purely management perspective, placement of these responsibilities in one user department is inherently imbalanced and creates the need to establish new independent oversight elements in other VA organizations whose ability to accomplish such oversight effectively is problematic.

7. Based on these factors and concerns, I have concluded that the capital facilities and real property programs within the VA must be consolidated and must be preserved as an independent staff office function. Consistently with Mr. Walters' proposal of last October, I, too, am firmly convinced that the Facilities Engineering, Planning and Construction (FEPAC) Office functions in DM&S and the Office of Construction must be consolidated into one unit. Accordingly, I have decided to transfer to the Office of Construction the personnel, resources and functions of the Facility Engineering, Planning and Construction Office in DM&S with the exception of the following FEPAC functions more appropriately retained by DM&S and nine (9) FEPAC FTEE to support these functions:

- o Facility Activation Staff;
- o Occupational Safety and Health;
- o 2 FTEE in FEPAC's Facility Planning Support (ADP) staff to develop appropriate budget and ADP interfaces; and

o the nonstructural fire and safety functions of issuance of certificates of equivalencies to the Joint Commission on Accreditation of Hospitals (including review and approval of all consultant fire safety evaluation system (FSES) analyses, approval of plans of corrective action, final approval of completed fire and safety work, and accomplishment of the second (internal) FSES analysis); issuance of operational fire and safety procedures and guidelines for VA facilities (e.g., evacuation procedures); establishment of guidelines, standards and procedures for VA fire departments; development and conduct of all fire protection training programs for all VA facilities; and investigation of fires in VA facilities. DM&S will retain its role as the VA element responsible and having jurisdiction for directing policy for all fire protection matters on an agencywide basis similar to the role that the Designated Agency Safety and Health Official (DASHO) has for directing agencywide occupational safety and health policy and agencywide asbestos policy.

It should be noted that in addition to the nine FEPAC FTEE to be retained by DM&S, DM&S also will retain the positions and incumbents of the seven construction coordinator positions already established in DM&S regional offices. These 16 FTEE will provide the necessary staff support for DM&S interface and liaison with the Office of Construction. The distribution within DM&S of the nine FEPAC FTEE will be at the discretion of the Chief Medical Director.

8. Inasmuch as the provisions of 38 U.S.C. section 210(b)(2) do not apply to this realignment, this transfer of functions and FTEE will be effective July 31, 1986, through employee details (not to exceed 64 FTEE) from FEPAC to the Office of Construction to facilitate the transition. A budget amendment will be prepared for FY 1987 to reflect this transfer and the transfer of funding for the affected FEPAC elements from Medical Administration and Miscellaneous Operating Expenses (MAMOE) to Construction Minor (General Administration). Therefore, effective July 31, 1986, from the FY 1986 FEPAC ceiling of 78, 64 FEPAC FTEE will be detailed to the Office of Construction and effective October 1, 1986, these 64 FTEE will be permanently transferred to the Office of Construction. Nine FEPAC positions will be retained in DM&S. The remaining 5 FEPAC FTEE will not be filled in order to achieve the previously agreed upon FY 1987 ceiling of 73 for the former FEPAC elements. Effective October 1, 1986, the newly combined FEPAC and O/C offices will be renamed "Office of Facilities", to reflect more appropriately its responsibilities for overall management of an integrated facilities program, including real property and space management in addition to its project planning, design and construction activities.

Department Heads, Associate Deputy Administrators, Staff Office Directors, and all Field Stations

9. With respect to this decision, the following responsibilities are defined:

- The Chief Medical Director, the Chief Benefits Director, the Chief Memorial Affairs Director and Staff Office Directors will be fully responsible for establishment, definition and projection of their program needs and the prioritization of those program needs (e.g., MEDIPP). In turn, these program needs will be provided in a timely manner to the new Office of Facilities, for incorporation into agencywide facility development planning and the ultimate planning, design and construction of specific projects. DM&S will continue to be responsible for sizing models, including the VA-GAO Bedsizing Model, and will provide this data to the Office of Facilities for translation into project specific requirements.

- The Associate Deputy Administrator for Logistics will be responsible for policy level oversight of the VA's capital facilities and real property programs. The Office of Facilities will report to the ADA for Logistics.

- The Director, Office of Facilities, will be the senior VA management official fully responsible and accountable for the overall Agency capital facilities and real property programs.

- Based on DM&S medical program planning data and the program planning input of DVB (if colocation of a regional office is involved) and DMA (if a VA cemetery is involved), the Office of Facilities will be responsible for preparing and implementing facility development plans for all VA medical centers as recommended by the Booz, Allen/RTKL report. It also will be responsible for all Major, Minor, Minor Miscellaneous and Nonrecurring Maintenance (NRM) project planning, design and construction in support of all VA Department and staff office needs. In general, Minor, Minor Miscellaneous and NRM projects will continue to be delegated by the Office of Facilities to the field for accomplishment in accordance with Office of Facilities management guidelines and oversight. Selected Major projects also may be proposed for delegation to the field where appropriate. Also in support of all VA elements, the Office of Facilities will have prime responsibility for all leasing, work space management and real property management (e.g., land acquisitions/disposals, land utilization surveys, environmental compliance and historic preservation). Execution of these programs may be delegated by the Office of Facilities to field units as appropriate. Based on the Departments' program planning data and priorities, the Office of Facilities will establish project priorities for inclusion in nationwide construction planning documents (e.g., Five Year Medical Facility Plan), prepare those nationwide construction planning documents, develop project schedules (e.g. Advance Planning Fund and Design Fund lists), and prepare budget submissions. These documents will be approved by the affected Department head before being finalized. The Office of Facilities, similar to the Offices of Procurement and Supply and Personnel and Labor Relations role with each medical center's Supply or Personnel Services, also will provide policy guidance to the medical centers' Engineering Service, including liaison with field facility engineers, for the resolution of facility maintenance problems. Field Engineering Service personnel, like field Supply and Personnel Service personnel, will remain DM&S employees. In this capacity field engineering service personnel will receive administrative direction from the Station Director and program direction from the Office of Facilities. The selection of Chief Engineers will be accomplished in the same manner as the cooperative roles of the Offices of Procurement and Supply and Personnel and Labor Relations and DM&S in the selection of Chiefs of Supply and Personnel.

- The Director, Office of Budget and Finance (Controller), will continue to monitor the construction and leasing appropriations process and compliance with related laws, regulations and directives. The three FTEE scheduled for transfer from the Office of Construction to the Controller in FY 1987 to enhance financial oversight and accountability of the Agency's capital facilities program will be transferred with support resources to the

Controller effective October 1, 1986. The Controller's financial oversight role in the facilities program will continue as it is presently performed with the enhancement of the additional staff. This transfer was reflected in the VA's February 5, 1986, budget submission to Congress. The Controller and his staff will have full access to all project planning, design and construction information as well as leasing and general property management information. The involvement of the Controller's staff in the initial development of facility development plans also is essential in that these plans will form the cornerstone of the Agency's construction program. Inasmuch as there will no longer be a need for an independent facilities program oversight function, the 10 FTEE proposed for transfer in FY 1987 from the Office of Construction to the ADA for Management to staff such function is hereby cancelled.

- The General Counsel will continue to review all leasing and construction-related contractual actions, all land transactions and all environmental compliance issues for legal sufficiency in the manner in which it is presently performed.
- The Director, Office of Procurement and Supply, will be responsible for providing technical acquisition and personal property management advice, including coordination of equipment and systems purchases with supporting construction projects, in the manner in which it is presently performed.
- The Director, Office of Small and Disadvantaged Business Utilization will be responsible for providing technical advice on matters relating to socio-economic program requirements in the manner in which it is presently performed.

10. The following implementation assignments are made:

- The ADA for Logistics is charged with development of an implementation plan for the Booz, Allen/RTKL study core process recommendations. I request that the ADA for Logistics provide me with periodic progress reports.

8.

Department Heads, Associate Deputy Administrators, Staff Office Directors, and all Field Stations

- The Controller is charged with immediately preparing the necessary amendments to the FY 1987 budget request to effect the transfer of the resources, FTEE and functions of the affected FEPAC elements to O/C on October 1, 1986, and transmitting these amendments to the appropriate Congressional committees.

- The CMD, and the Director, Office of Construction, are charged with developing a detailed realignment and action plan for the effective organizational integration of O/C and the functions and personnel of affected FEPAC elements which is to be effected October 1, 1986. The Office of Personnel and Labor Relations will assist the affected organizations in preparing the necessary documentation to implement the interim employee details which will be effective July 31, 1986, and is available to assist DM&S and O/C's joint development of the detailed realignment and action plan. I have reviewed the December 31, 1985, organizational proposal for this merger submitted to Administrator Walters and approved by him on January 3, 1986. With the exception of the FEPAC functions listed in paragraph 7 above, more appropriately retained in DM&S, the same realignments and consolidations will result from my decision as proposed in the December 31 memorandum. I ask that the December 31 proposal be refined and updated as needed and submitted to me for review no later than August 15, 1986. This plan also should reflect the necessary space planning to physically relocate affected FEPAC staff to the Lafayette Building. If space requirements do not permit a full consolidation, the plan should reflect which organizational element(s) in the new Office of Facilities will remain in the VACO headquarters building. The plan also should include the transfer of any FEPAC equipment and software support necessary for the Office of Facilities to accomplish its work. DM&S and O/C will need to work with the Office of Program Analysis and Evaluation to ensure that the realignment package reflects the requirements of MP-1, Part I, Chapter 7.

- The CMD and Director, Office of Construction, in coordination with the Director, Office of Personnel and Labor Relations, will propose to me procedures for the recruitment, training and selection of Chief Engineers under the new realignment. This report also should cover issues of training and recruitment for other employees in VAMCs' Engineering Services and the funding and the supervision of engineering training facilities in Little Rock and St. Louis. I ask that these draft procedures be submitted to me by August 15, 1986.

- In FY 1987, I ask that the Controller fully assess his FTEE requirements to effectively ensure financial oversight of the Agency's capital facilities, leasing, and real property programs and advise me of his FTEE needs so that these can be reflected in appropriate budget documents.

- The Director, Office of Construction, in coordination with DM&S, DVB, DMA, the Office of Information Management and Statistics, and other appropriate staff offices, will identify and develop a plan for revising existing circulars, manuals, etc., as necessary to reflect this realignment and provide this plan to me by September 1, 1986.

- I ask that the ADA for Management, through the Office of Program Analysis and Evaluation, and the Director, Office of Personnel and Labor Relations, offer full assistance to affected elements to facilitate implementation of these decisions.

11. In announcing these decisions, I wish to emphasize the critical importance that our facilities program fully support and be responsive to the needs of the client Departments, staff offices, and field facilities. The VA's capital facilities and real property holdings are Agency resources. By this realignment, the Office of Facilities is entrusted with full responsibility to support, maintain and improve these Agency assets. At the same time, it is just as important that the facility support needs of those who work in our facilities are fully met in a timely fashion in order that they can efficiently and effectively carry out their vital field services to veterans. To ensure this end, the new Office of Facilities must work fully, openly, directly and in

partnership with field users. Mechanisms will be established and proposed to me for approval by the Office of Facilities, in coordination with the Chief Medical Director, which will ensure a cooperative and meaningful working relationship between the new Office of Facilities and DM&S field facilities, medical program planners, professional services and Regions. I specifically request that among the mechanisms included in this proposal, the Office of Facilities include an assessment of assigning an Office of Facilities health care facility planner to each DM&S regional office to assist field facilities in planning for capital facility investments. The Office of Facilities also will develop similar mechanisms to ensure a fully responsive working relationship with DVB and DMA. This report is due to me on August 15, 1986.

12. The Administrator's announcement of October 31, 1985, is withdrawn only insofar as it may conflict with these decisions. The VA's request to Congress of February 5, 1986, to waive the requirements of 38 U.S.C. section 210(b)(2) is hereby rescinded. The Administrator's decision memorandum of December 16, 1985, "Establishment of an Associate Deputy Administrator for Management - IMPLEMENTATION", is amended to the extent necessary to reflect the decisions in this memorandum.

THOMAS K. TURNAGE

QUESTIONS AND ANSWERS ON THE CONSOLIDATION OF DM&S AND OFFICE OF CONSTRUCTION FUNCTIONS INTO AN INDEPENDENT OFFICE OF FACILITIES

1. State the number and responsibilities of the employees which will be added or moved from each affected office.

ANSWER: 64 of the 73 authorized FY 1987 FTEE ceiling for the Department of Medicine and Surgery's Facility Engineering, Planning and Construction Office (FEPAC), will be transferred to the Office of Facilities and become employees of that office. The specific responsibilities of each employee will be determined by the Director of the Office of Construction, as part of the new organizational realignment and implementation of the Booz, Allen core process recommendations to improve the planning for facilities construction in the Veterans Administration. The total FY 1987 FTEE ceiling for the Office of Facilities will [illegible]. (Also see question 33.)

2. Describe the changes in functions that will occur at each affected office.

ANSWER: The overall function of FEPAC and the Office of Construction will not change, in that the consolidated Office of Facilities will continue to be responsible for the same functions for which the two separate offices are currently responsible; that is, maintenance and physical plant operations at the medical centers, real property and space management, and the VA's facility planning, design and construction programs. The consolidation of the two offices into an integrated Office of Facilities, however, will eliminate duplication. In addition, as the Booz, Allen core process recommendations are implemented, form will be adjusted to reflect function.

3. State the reasons why you have determined that this realignment is appropriate and advisable in terms of the statutory missions and long-term goals of the Veterans Administration.

ANSWER: The Booz, Allen & Hamilton/RTKL Study found that the Agency's health care facility planning process which the Veterans Administration employs needed to be strengthened in several ways, and that in the long run, medical program planning and VA health care facility planning should be fully integrated through the mechanism of facility development plans. However, the Veterans Administration also is responsible for the maintenance, planning, design and construction of nonmedical facilities, and for work space management and real estate management, acquisition and disposal, maintenance, leasing and purchase of VA facilities. Therefore, in order to achieve the planning improvements as recommended by Booz, Allen, while at the same time maintain an independent Office of Facilities, whose primary mission is to serve the integrated capital facilities needs of all VA elements, I determined that the retention and enhancement of an independent staff office is the most efficient and logical organization.

4. Describe the effects that this realignment may have on the provision of benefits and services to veterans and dependents of veterans (including the provision of benefits and services through offices and facilities of the VA not directly affected by the realignment).

ANSWER: I anticipate that this realignment will improve the provision of benefits and services to veterans and their dependents significantly, by improving our entire facilities planning process, streamlining our procedures, shortening project development time, improving our criteria and standards, ensuring a single source of accountability, and enhancing field facility participation.

5. State your estimate of the cost of implementing this realignment immediately, and state the long-term costs of implementing this realignment.

ANSWER: The only near term cost of implementing this realignment is the inherent and necessary one of minor relocation costs (installation of phone lines, minor renovation of office space, etc.) when personnel are reassigned from one office to another.. I do not anticipate long-term costs; rather I anticipate long-term benefits and cost savings.

6. What will happen to the 10 FTEE that you have announced would be transferred from the Office of Construction to the Office of the ADA for Management for a facilities oversight function, and the 3 FTEE scheduled for transfer to the Controller to enhance fiscal oversight of the construction program?

ANSWER: Inasmuch as there will no longer be a need for an independent facilities oversight function, residing under the Office of the ADA for Management, the FTEE that initially were to be transferred from the Office of Construction to the Office of the ADA for Management will not be transferred. The three FTEE for the Controller will still be transferred effective October 1, 1986, because of the existing need for enhanced fiscal oversight. I have asked the Controller to assess this three FTEE level and ensure it is sufficient to meet the job that needs to be done.

7. How will your realignment address the loss of control that DM&S feels over influence over construction planning and delivery, and the great user dissatisfaction with products expressed by DM&S in the past?

ANSWER: As the Veterans Administration responded on October 31, 1985, to a question posed by Mr. Marty Reiss of the Senate Committee on Appropriations Staff:

> There is a consensus among all VA elements involved in the construction program that a *marked improvement* in communication and field participation in the entire process *has been achieved* during the past two years. This effort was underway before the consultant study began. The development of the new system to prioritize the selection of construction projects also is currently in use. Among other initiatives, the VA also has moved forward in the area of prototyping; has initiated a comprehensive study of the physical plant conditions of the VAMCs to improve our planning data base, has undertaken a comparison of its construction standards and specifications with the private sector; and initiated a design fund to shorten project development time. (Emphasis added.)

With regard to recent enhancements of user participation, the following initiatives also were undertaken in the last few years: VAMC participation in architect-engineer (A/E) selections; VAMC concurrence in the selection of, and participation in, evaluation of Resident Engineers; increased emphasis on the need for, and value of, cooperation and flexibility; and the formation of an ad hoc committee to make further recommendations for improvement. Therefore, we feel that we have already made great strides toward significantly enhancing the opportunities for user participation in the VA construction process. In addition, implementation of the Booz, Allen core process recommendations will facilitate and greatly accelerate the actual construction and delivery of the product to the user by shortening the initial planning process considerably. User satisfaction should be additionally enhanced by the faster delivery of the desired product.

Most significantly, however, the institution of facility development plans (FDPs) for each of our medical centers, as recommended in the Booz, Allen Study, also will involve the VAMCs to a greater extent than ever before in initial planning. The FDPs will be wholly based on DM&S' medical program needs and priorities and will be approved by the Chief Medical Director. In addition, DM&S will continue to approve all major milestones in project development, ensuring its participation and control over needs and priorities throughout the process.

8. How will this realignment affect the lack of responsiveness of the construction program to user needs?

ANSWER: This realignment will result in an integrated, consolidated capital facilities and real property program which, when combined with implementation of improvements in our processes and procedures as recommended by the Booz, Allen & Hamilton/RTKL Study, will greatly enhance planning, the involvement of the VAMCs in that planning, and, hence, responsiveness to client needs.

9. With this realignment, is there a single accountable decisionmaker in the facilities construction program below the Office of the Administrator?

ANSWER: Yes. There is a single accountable decisionmaker for facilities construction for the Veterans Administration below the Office of the Administrator: that is the Director of the Office of Facilities, whom I shall hold responsible for all aspects of capital facility planning, design and construction, as well as other aspects of facilities, including leasing and land management. At the same time, all three directors of the departments will be responsible for their program delivery; for example, the Chief Medical Director will continue to be responsible for medical program delivery and planning. The Director, Office of Facilities, will report through the Associate Deputy Administrator for Logistics who will oversee the management of the Agency's capital facilities and real property programs to ensure they achieve the maximum efficiency and effectiveness expected from this realignment.

10. How will this realignment affect the excessive delivery time for projects?

ANSWER: In time, we expect to significantly reduce the duration to plan, design and complete construction projects. This will occur primarily through enhancements in the planning process that will avoid project recycling, as well as through improvements in the quality of basic planning data. Additional time savings will be realized by eliminating duplication and streamlining our current operations.

11. Does your proposed realignment limit the duplication, overlap, and fragmentation complained of before?

ANSWER: Booz, Allen & Hamilton identified duplication, overlap and fragmentation in the health care facilities planning process, as well as in the construction management process. That duplication, overlap and fragmentation occur primarily between FEPAC in the DM&S (and to a lesser extent, the Regional Directors in the DM&S) and the Office of Construction. As far as facilities planning goes, this realignment, by combining FEPAC into the Office of Construction, should eliminate the duplication, overlap and fragmentation. In addition, I believe and anticipate that we will be able to eliminate the duplication, overlap and fragmentation in the project management functions as well by implementing a project manager concept in which a project management office will manage a project from project plans through construction and financial completion. The project manager, however, will not begin work on a project until the planning element has completed its responsibility, thereby achieving a crisp transfer of authority and responsibility for a specific project at a defined point in development.

12. How will your realignment affect or improve oversight of the construction program?

ANSWER: The construction program, as it is currently organized, is operated primarily by the Office of Construction which plans and executes all major construction projects, with the exception of a few projects which are delegated to medical centers. The Office of Construction also assists in the planning of minor construction projects for the three departments. Minor and nonrecurring maintenance (NRM) projects, however, are managed by the Department of Medicine and Surgery. Other capital facilities related functions are split between O/C and DM&S. In the past, this has led to confusion over who is responsible for what. Under this realignment, the Office of Facilities will be fully responsible for all aspects of an integrated capital facilities program agencywide. This will greatly facilitate the Office of Facilities' ability to manage and oversee the entire program and centralizes, in one spot, responsibility for performance. In addition, there will continue to be legal and fiscal oversight of the budget of the construction program by the General Counsel and the Controller of the Veterans Administration, respectively. Additional FTEE resources will be placed in the Controller's office for fiscal oversight. The reorganization as proposed by my predecessor, Mr. Walters, would have necessitated a different process for oversight. My realignment will perpetuate and enhance the existing oversight system.

13. How will your proposed realignment be compared to Mr. Walters' proposed reorganization regarding all the improvements that he anticipated when he decided to incorporate the Office of Construction within DM&S? Specifically, address efficiency, responsiveness of planning, creating a single point of accountability, and improving user influence on the product.

ANSWER: I firmly believe that my proposed realignment will achieve the same process improvements as would Mr. Walters' proposed reorganization, in that the efficiency and responsiveness of planning will be improved, and the duplication and overlap of management responsibility for the facilities construction program will be eliminated. In addition, it will continue to improve and maintain our recent improvements in achieving user satisfaction with the end product. At the same time, this realignment should avoid several disadvantages of the previous reorganization proposal which I think are inherent in that proposal. First, a staff office will remain which is designed to serve the entire Agency's facilities needs, independent of any one particular user. Second, the Chief Medical Director will not be distracted from his primary mission of providing medical care to the nation's veterans, because he will not additionally be responsible for the capital facilities program for his department, as well as for the Departments of Veterans Benefits and Memorial Affairs and several of the VA staff offices.

14. How will this realignment affect the budget, and appropriations requests to Congress, and specifically the construction budget as a whole?

ANSWER: This is a question where some uncertainties remain at this time. Naturally the major construction budget for the agency as a whole will continue to be funded as a separate line item by Congress, and requested as such by the Veterans Administration with the approval of OMB. The minor construction program is funded as a separate line item by Congress and will continue to be done in this manner for the foreseeable future. The budget for nonrecurring maintenance at medical centers, which is clearly a capital expenditure, has a line item in the VA medical care budget. Whether it should remain so, or be funded within the other construction accounts, is an issue which will be comprehensively assessed. As part of this assessment, we also will review the effectiveness of the current classification of projects of Major, Minor, Minor Miscellaneous and NRM.

15. What will be the responsibility, and the line of authority for the VAMC Engineering Service employees who are now employees of the DM&S, under the direction of the Engineering Service within FEPAC?

ANSWER: The VAMC Engineering Service employees (as distinguished from the resident engineers who are employees of the Office of Construction, on site for major construction projects) are the employees of the Department of Medicine and Surgery. These engineering employees are assigned to each medical center; they are responsible for the maintenance and operations of the physical plant, safety programs and maintenance of personal and real property of each medical center, and for the supervision of nonrecurring maintenance projects, minor miscellaneous projects, minor projects and major projects when they are delegated to the medical centers for execution and administration. Currently the VAMC Engineering Service employees' work performance on the job is evaluated by medical center Directors; they receive their technical direction and advice from the Central Office Engineering Service, within FEPAC in the Department of Medicine and Surgery. Although DM&S Engineering Service and FEPAC will become a part of the Office of Facilities, these facility engineering employees will remain as medical center employees. However, their program and technical direction will be provided by the Office of Facilities, in a manner very similar to the Chiefs of Supply at medical centers, who now obtain their contracting authority, policy and technical guidance from the Office of Procurement and Supply, while organizationally reporting to and receiving administrative direction and performance appraisals by medical center Directors. The realignment does not change the current situation, except that program and technical direction will now come from the Office of Facilities rather than FEPAC.

16. How will the VAMC Engineering Service employees be responsive to hospital center Directors for day-to-day operations and maintenance of hospitals?

ANSWER: Like VAMC Supply Service employees, the VAMC Engineering Service employees will continue to be employees of the Department of Medicine and Surgery, and therefore responsive to hospital center Directors for day-to-day operations and maintenance of the hospitals. The only thing that will change will be that the responsibilities for the Engineering Service within FEPAC will be now performed by the Office of Facilities. In effect, this means that agencywide policy issues in the engineering area will be exclusively held by one office--the Office of Facilities--rather than split between the Department of Medicine and Surgery and the Office of Construction as it is now.

17. How will this affect your 1987 budget requests? 1988 budget requests?

ANSWER: As to the 1987 budget requests, we will have to modify our requests, since the current 1987 requests have reflected the transfer of the Office of Construction to the Department of Medicine and Surgery. There will be no change in the appropriations authority in line items for Major, Minor and NRM in the FY 1987 request. When our FY 1988 budget request is formulated, it will reflect this realignment.

18. How will this affect or disrupt the construction process as it is going on right now?

ANSWER: I firmly believe that the realignment should not disrupt the construction process as it is going on right now. The actual construction for major projects is the supervisory responsibility of the Office of Construction as it exists now and that will not change. Under this realignment, no change will occur to construction projects that are delegated to the medical center Director for development and construction. In fact, we believe that the construction process will, as a result of the implementation of the Booz, Allen core process recommendations, be accelerated significantly, by virtue of time savings in the initial planning processes.

19. The Booz, Allen/RTKL report said that there was fragmentation of process management functions between the Office of Construction and DM&S which has been "purposely fostered . . . to provide a check on DM&S in defining facility construction requirements and in carrying out projects to meet those requirements," and that "this structure does provide an effective check on the process" (page ES-9). However, noted Booz, Allen, the cost is "enormous" in that it results in "confusion over who is actually responsible for managing the process," and results in a "lack of clear accountability" for management control responsibilities. Will your proposed realignment perpetuate that problem?

ANSWER: Both the previous reorganization proposal and mine are designed to address specifically this concern about fragmentation of process management functions made by Booz, Allen. My realignment proposal also places accountability for the Veterans Administration capital facilities program in one person--the Director of the Office of Facilities. What will remain in the Department of Medicine and Surgery is medical program planning. Medical program planning and medical facility planning are integrated through the facility development planning process. Facility planning does not begin until medical program planning has identified the needs and priorities. Hence, the same crisp hand-off between these management functions occurs under either proposal and responds to the Booz, Allen/RTKL concern.

In addition, I do not find as persuasive the concern that placement of both oversight and technical support responsibilities in the Office of Construction results in conflicting roles within the Office of Construction, of support for the client, plus policing of the process. What the Office of Construction is "overseeing" is enforcement of the VA's standards, criteria, policy and Administrator guidance. If accomplished correctly and professionally with their technical support role, this should not result in conflict except insofar as the client requests deviations from these standards and criteria. In this latter case, our current system allows some flexibility in our design standards and criteria, and if legitimate professional differences of opinion occur, these will be elevated, as necessary, to progressively higher levels of management for resolution.

20. The Booz, Allen/RTKL report specifically did not recommend either that the Office of Construction become a part of DM&S, or that FEPAC become a part of the Office of Construction, saying that the recommendations made in the report "stop short of full integration . . . ; moving too far, too fast, may result in serious disruptions of both (health care and construction) programs, especially during a period when other reorganizations are taking place within DM&S. Full integration without necessary oversight mechanisms (now provided, in part, by O/C) could affect program integrity." Will your proposed realignment create exactly the disruptions which Booz, Allen warned of?

ANSWER: My realignment will not create the disruptions mentioned in Booz, Allen any more than the previous reorganization proposal would have done. In the first place, the reorganization of DM&S is complete now. In the second place, my examination of the construction process has led me to believe that the construction process as it is going now can only be improved by the assimilation of the facility planning function of DM&S and the Office of Construction into one facility planning service under the Office of Facilities. Finally, it is the consensus of both DM&S and the Office of Construction that a complete marrying of the two organizations one way or the other was essential to improving the facilities planning process. As noted previously by O/C and DM&S, aligning facilities planning and project planning recognizes that the best environment for facility planning is created when a single organizational element is responsible for coordination and for providing assistance to the field in the development of potential solutions for correcting facility related problems.

21. How will the MEDIPP process be now integrated into planning under your proposed realignment?

ANSWER: The MEDIPP planning process, as it currently exists, is a very useful tool for identifying needs for future medical care facilities generally. Planning those solutions, and translating those distinct needs into specific facilities will be the purpose of the facility development plans recommended in the Booz, Allen/RTKL report as part of its core process recommendations. We strongly support the Booz, Allen recommendation to formulate facility development plans for our medical centers. This approach will incorporate the MEDIPP requirements data and identify all possible solutions to identified needs. Indeed, the facility development plans will be based on DM&S medical program planning and priorities providing a full interface between the two processes.

22. One of four short-term problems identified by Booz, Allen was the need to improve space planning criteria; what does your realignment do to effect that?

ANSWER: The organizational realignment, in and of itself, does not directly affect the quality of our currently existing space planning criteria. However, separately, I intend as part of the implementation process for the Booz, Allen core process recommendations, to direct that we substantially improve our space planning criteria and use it as an important tool in the determination of facility needs as part of our facility development plans. Currently, our criteria are not based on well-defined medical care operating modalities, nor are there standardized medical care operating modalities for the various levels of care we provide. As such, our criteria are not well accepted by the field. In addition, in many instances, our criteria are outdated, and we need to vastly improve the immediate feedback of lessons learned through our post occupancy evaluation of completed facilities into our criteria.

23. How will this realignment affect the core process recommendations made by the Booz, Allen/RTKL Study?

ANSWER: This realignment will not directly affect the core process recommendations one way or the other; rather, separately we are moving forward to implement the core process recommendations made by Booz, Allen, because we think they are good ones and useful ones. We do believe however that this realignment will facilitate the implementation of those recommendations by eliminating the fragmentation between FEPAC and the Office of Construction that currently exists in the area of initial project planning.

24. Will DM&S continue to prepare the Five-Year Construction Needs Assessment?

ANSWER: No. The Office of Facilities will prepare the needs assessment, based ultimately on the facility development plans for each medical center, as a summary of the medical care planning requirements and priorities tied to the MEDIPP process and provided to them by DM&S. The document, however, will be fully coordinated with DM&S and approved by the Chief Medical Director before it is finalized.

25. What will be the approval and funding process for a medical center to change a project?

ANSWER: With the new facility development plan process in place and ample opportunity to participate in specific project development through the Advance Planning Fund (APF) process and working drawing design, it is hoped that the need for changes after a project is in a budget will be dramatically reduced.

Medical center requested changes during working drawings or construction, however, would continue to be submitted through the DM&S Regional Offices, for screening and appropriateness, to the Office of Facilities (O/F). The O/F, in turn, will be responsible for coordination and approvals, including the provision of additional funding.

26. What overall improvements will result from your realignment?

ANSWER: The consolidation of FEPAC and the Office of Construction will achieve several improvements. This transfer will:

- create a unified system for the Agency's capital facilities and real property programs with a single focus of management authority, responsibility and accountability;
- create opportunities for elimination and/or reduction in overlapping authorities, duplication, fragmentation and redundancies in the existing organizational structure and processes and produce potential for achieving greater economies;
- enable users (medical center Directors and other line and program officials) to more actively participate in the health care facility planning and construction process by providing a direct interface and through the facility development plan process;
- assure the level of support required by the facility programs of the three VA departments (Department of Medicine and Surgery, Department of Veterans Benefits and Department of Memorial Affairs) and staff offices; and most importantly,
- ensure that the facilities in the field are appropriately planned, designed and constructed to enhance the care and service provided to the nation's veterans consistent with the economical use of resources.

In point of fact, these are the same improvements which would be achieved under any organizational alignment which integrates the Agency's capital facilities programs in one organizational element.

27. How will the chain of command work under your realignment?

ANSWER: The realignment places the Director of the Office of Facilities as the single point of accountability for the total VA capital facilities and real property programs, reporting to the ADA for Logistics, who has responsibility for policy level oversight of the Office of Facilities. The responsibilities of the Director, Office of Facilities, begin when the Departments conclude their assessment of nationwide program needs and the priority of those needs.

28. Was your consolidation of FEPAC and the Office of Construction into an independent Office of Facilities previously considered by Administrator Walters?

ANSWER: Five organizational options were considered by Administrator Walters. The Booz, Allen/RTKL Study identified three options, based on their study of the health care facilities construction process (the study did not address the construction programs of DVB or DMA):

Option 1: Consolidate planning activities in DM&S.
Controlling activities remain split between DM&S and the Office of Construction.

Option 2: Consolidate planning activities in DM&S.
Consolidate control activities in the Office of Construction.

Option 3: Consolidate both planning and control in DM&S. The Office of Construction provides architectural/engineering support and design and construction services.

In viewing the consultant options, the Veterans Administration identified two additional alternatives. These alternatives were predicated on the belief that the opportunity exists to move further toward the ultimate goal recommended by Booz, Allen & Hamilton/RTKL Associates, a fully integrated Health Care Facilities planning and delivery process. These alternatives were:

Option 4: Integrate the Office of Construction and DM&S activities in DM&S.

Option 5: Consolidate all construction and facility-related activities in the Office of Construction.

The primary difference between Mr. Walters' proposed organizational response and mine is that I strongly believe the VA's facilities programs, and the oversight and control over those programs, will be better served by placing them in an independent staff office function.

29. What will be the role of DM&S in the construction process?

ANSWER: The DM&S will continue to have full and sole responsibility for defining and prioritizing their programmatic needs which require capital improvements. In addition, the Office of Facilities will continue, in general, to delegate, to the medical centers, the responsibility to execute and administer nonrecurring maintenance, minor miscellaneous and minor construction projects, as well as selected major projects. The Office of Facilities and the medical centers will work closely to translate the Department's program needs into individual facility development plans which in turn will be reviewed and approved by the Chief Medical Director. Project specific activity will be closely coordinated with the affected medical centers. In addition, throughout the facility planning process, there will be active involvement by the DM&S Regions and the close and active interface of the Office of Facilities with the Assistant Chief Medical Director for Planning, Evaluation and Systems Development, as well as the other ACMDs.

30. The Facility Development Plan (FDP) seems to be the centerpiece of the seven core process recommendations made by Booz, Allen & Hamilton/RTKL Associates. What kind of assumptions are you making, if any, with respect to implementing the FDP?

ANSWER: The Facility Development Plans provide a strategic context within which to identify individual facility needs in priority order on a system-wide basis. These projects will become the basis of the agency's Five-Year Needs Assessment and construction budget request. Our assumptions are as follows:

- o Linkage between the MEDIPP and construction planning is in place to begin the FDP implementation stage;
- o Standards are adequate to begin the FDP implementation stage;
- o Current linkage between construction program planning and medical program planning is adequate to begin implementation;
- o An adequate budget process is currently in place to begin FDP;
- o Prioritization of construction projects will be improved based on the FDP implementation;
- o Health planners and architect-engineers will be used as consultants in the development of the FDP;
- o Planning data base will be initiated at the problem definition stage and will be continuously built upon during the FDP process;
- o Major, minor, minor miscellaneous and nonrecurring maintenance and repair construction needs will be addressed; and
- o Physical plant assessments are available.

31. Will we now see DM&S create a new staff to interface with the Office of Facilities?

ANSWER: No. There will be no need for such a staff in DM&S. The Office of Facilities will work directly with the existing DM&S medical program planners, regions, professional services and the field facilities. There is no need to create any additional organization in DM&S. Rather, what is needed is the proposed approach which will foster direct communications.

32. Will the realignment result in FTEE savings?

ANSWER: Yes. The Office of Construction's original FY 1987 FTEE request was 710. This was reduced to 660 to reflect an intra-agency transfer of 13 FTEE (10 to the ADA for Management and 3 to the Controller), a general 1 percent productivity improvement savings of 7 FTEE, and a 30 FTEE reduction as estimated by the Booz, Allen/RTKL Study in anticipation of the organizational consolidation. In addition, FEPAC's FY 1986 ceiling of 78 was reduced by 5, in FY 1987, to 73 in anticipation of consolidation efficiencies. The realignment will transfer 64 of these 73 positions to O/C, as well as transfer (i.e., retain in O/C) the 10 positions originally intended for transfer to the ADA for Management. This brings the FY 1987 ceiling for the integrated Office of Facilities to 734 as compared to 788 FTEE, which was the combined original FY 1987 O/C and FEPAC staffing request. As the above figures show, the net FTEE savings already achieved are -54 FTEE (if you base the figure on O/C's original FY 1987 FTEE request) or -28 FTEE (if you base the figures on the current combined FY 1986 ceiling of O/C (684) plus FEPAC (78)) or a base of 762. Further staffing efficiencies, if justified, will be pursued as the core process recommendations are implemented.

33. Currently the Regional Safety and Fire Protection Engineers (RSFPE) report to DM&S Regional Directors. What will be the organizational structure and role of the Regional Safety and Fire Protection Engineers when the realignment takes place?

ANSWER: The Regional Safety and Fire Protection Engineers will continue to report to Regional Directors within DM&S. Their current responsibility is to perform fire, safety and occupational health related duties, such as industrial hygiene, the Joint Commission on Accreditation of Hospitals (JCAH) and OSHA compliance, site inspections and review of construction project submissions, drawings and specifications. They will continue to do so under this proposed realignment.

Currently, the RSFPEs receive Central Office policy guidance concerning occupational health and safety related issues (primarily, guidance on implementation of OSHA regulations) from the Designated Agency Safety and Health Officer (DASHO), who is responsible to advise on implementation of these regulations agencywide. The DASHO is an independent function presently located within DM&S. Under the realignment, that function will remain where it is, and the agencywide responsibilities will not change. Insofar as the RSFPEs are responsible for occupational health and safety implementation within their regions, they will continue to report to the Regional Directors and continue to receive their Central Office policy guidance from the DASHO.

With regard to Agency fire and safety functions, to preserve the critical need for an independent check and balance in the Agency's fire and safety program, DM&S also will continue to retain agencywide responsibility for directing policy for all fire protection matters VA-wide. In addition to its policy setting role (which includes approval of the Office of Facilities' fire and safety construction specifications), DM&S will retain the nonstructural fire and safety functions of issuance of certificates of equivalencies to JCAH (including review and approval of all consultant fire safety evaluation system (FSES) analyses, approval of plans of corrective action, final approval of completed fire and safety work, and accomplishment of the second (internal) FSES analyses); issuance of operational fire and safety procedures for VA facilities (e.g., evacuation procedures); establishment of guidelines, standards and procedures for VA fire departments; development and conduct of all fire protection training programs VA-wide; and investigation of fires in VA facilities.

The Office of Facilities, on the other hand, will be responsible for developing guidelines and procedures and policy (with the approval of DM&S) for all structural fire and safety matters, including development of maintenance oriented fire protection standards, development of maintenance, testing and inspection standards for fire protection equipment, and development of installation specifications.

In no other respect will any reorganization of the fire and safety personnel be made. The fire and safety personnel on the staff of the station Engineers at the medical centers will continue to report to those Engineering Officers who will report operationally to the medical center Directors and, through them, to the districts and regions.

34. Why not just retain FEPAC's Central Office Engineering Service in DM&S? Is this not more an operational than a construction responsibility?

ANSWER: To respond to this question, one needs to recognize the difference between a construction program and an integrated capital facilities program. The previous realignment proposal to combine O/C and FEPAC in an Office of Facilities in DM&S recognized the need to have Engineering Service in that office to ensure a fully integrated capital facilities program. The current realignment to have an independent Office of Facilities is and should be no different in ensuring achievement of that goal.

Field Engineering Officers will continue to be DM&S employees, similar to Supply Officers at each medical center. As such, recurring maintenance problems and day-to-day operational needs will be addressed as they always have been and performed by the Engineering Officers with general policy guidance by the Office of Facilities. The purpose of transferring the Central Office Engineering Service staff to the Office of Facilities is to provide a totally integrated facilities program which includes the Major, Minor, Minor

Miscellaneous and NRM programs. The role of the Office of Facilities will be to ensure this coordinated, integrated facilities program through policy guidance, technical direction and support, and advice to field engineering personnel. The role of medical center Directors is to provide supervision and administrative direction to the field Engineering Officers. Currently, the construction programs are fragmented from the rest of the NRM program. This results in coordination problems. It should be noted that the annual nonrecurring maintenance budget is huge--in FY 1984, the NRM program encompassed 78.2 percent of the health care facilities construction workload and accounted for 21.7 percent of the Agency's capital improvements dollars. With policy and guidance for Engineering Officers in the field coordinated with all other facility matters in the Office of Facilities, the nonrecurring maintenance program will be fully coordinated and integrated with all other capital improvements projects at the medical centers, districts and on a national level. At the same time, the Engineering Officers at each medical center will be directly responsive to the medical center Directors from whom they receive administrative direction. In short, the medical center Director retains the *administrative* control over the onsite operations and maintenance, with the Office of Facilities having *program* oversight and direction. Essentially, this means that the medical center Director will continue telling the onsite operations and maintenance officers *WHAT* has to be done, while the Office of Facilities tells those offices *HOW* to do it and ensures that the resources are available.

In addition, the distinction between operations and capital facilities concerns must be clearly made. Operational organizations within DM&S and at each medical center are concerned with delivery of medical care. Coordination of Minor, Minor Miscellaneous, nonrecurring maintenance and repair, and delegated Majors, biomedical engineering, maintenance and operation of the physical plant and structural safety and fire protection are capital facilities concerns.

The integrated facilities program now proposed eliminates institutional barriers which existed when FEPAC's Engineering Service was separated from O/C and places the vast technical and programming resources of O/C (O/F) directly at the disposal of, and in an operational responsibility to, the facility operations arm of the medical centers. And, as noted above, it does so without bridging the medical center Director's overall responsibilities.

Finally, the concern that Engineering Service's duties are not "construction" responsibilities reflects a misunderstanding about the role of the Office of Facilities. The Office of Facilities' role is not that of a "construction" only organization, but rather manager and provider of the VA's entire capital facilities and real property programs.

35. *Will not the transfer of DM&S' Central Office Engineering Service to the Office of Facilities diminish the responsiveness and flexibility of field engineers to meet day-to-day operational needs at VA medical centers?*

ANSWER: As noted previously, recurring maintenance problems and day-to-day and emergent operational needs will be addressed as they always have. The non-capitalized maintenance and repair work ($79.9M budget in FY 1987 to perform work of a sustaining nature to prevent or offset the physical deterioration of real property to maintain facilities at existing levels) will still be under local control just as it is now. It should not matter if facility engineers call a Central Office Engineering Service in DM&S or in the Office of Facilities as long as they get answers and timely action. In addition, the wider technical and administrative support in the Office of Construction (Office of Facilities) should greater enhance responsiveness.

36. Why transfer DM&S' Central Office nonrecurring maintenance and repair program to the Office of Facilities?

ANSWER: The VA's capital program is funded from two sources: the Construction account (includes Major, Minor and Minor Miscellaneous projects) and the Medical Care account (which, under object class 32, contains the four elements of the nonrecurring maintenance and repair program). The definitions of these four elements (BSER, BSEA, Minor Improvements, and M&R--capitalized and non-capitalized) clearly indicate the integral role of all of these elements, including M&R (non-capitalized), with facility construction. While on the surface it might appear as if M&R (non-capitalized) could be segregated from the NRM program, M&R (non-capitalized) is an integral part of NRM projects. For instance, you could have an NRM project, a portion of which could qualify for M&R (non-capitalized) funding. There is no reasonable or responsible way to break out M&R (non-capitalized) from the overall NRM program, which in turn, is a substantial portion of the VA's overall capital facilities program.

37. Why transfer DM&S' Central Office biomedical engineering program to the Office of Facilities?

ANSWER: Biomedical engineering consists of highly trained engineers who are responsible for managing and maintaining the complex clinical equipment programs at the medical centers. They currently report organizationally to the medical center Chief Engineer and, under the realignment, would continue to do so. As with everyone in the field Engineering Service, they also would continue to be DM&S employees with administrative direction from the medical center Director and program direction from the new Office of Facilities, just as it previously was with FEPAC.

Biomedical engineers are liaisons between the clinical and administrative sides of the house at the medical centers. They are the pivot point for equipment layouts, vendor selections, integration of complex medical equipment systems, and installation and maintenance of such equipment. As such, they are actively involved in the development of construction projects. The professional input of biomedical engineers in equipment layout strengthens the VA's acquisition planning and design, purchase and maintenance of major capital outlays by the Agency (e.g., CAT Scan, MRIs, radiology and nuclear medicine and other monitoring systems).

A case could be made for separating biomedical engineering out of Central Office's Engineering Service and making it a separate professional service in DM&S Central Office. However, again, this only fragments the goal of a fully integrated capital facilities program. When the Office of Construction was proposed for transfer to DM&S, it was determined that FEPAC's Central Office biomedical engineering staff should be retained in the DM&S' Office of Facilities to provide Central Office level biomedical engineering professional support and program development to the field biomedical engineers. This still makes sense under the independent Office of Facilities concept.

38. Who will be responsible for the VA's Art-in-Architecture Program?

ANSWER: Prior to September 20, 1984, the VA's Art-in-Architecture Program was administered by the Office of Construction. As of September 20, 1984, however, the Administrator delegated the Art-in-Architecture Program to the Department of Medicine and Surgery which, in turn, plans to delegate administration of this program to field facilities. Under the realignment, DM&S will continue to have jurisdiction over the Art-in-Architecture program.

39. Why not leave the planning component of FEPAC in DM&S? Wouldn't this ensure closer integration with MEDIPP?

ANSWER: Under the previous reorganization proposal, it was determined that the Agency would best be served by consolidating all facility planning, design and construction (and related activities) into one integrated capital facilities program. I fully agree with this previous conclusion, and my realignment reflects this concept.

The closer integration of MEDIPP with facility planning will occur in two ways: first, with better and more timely MEDIPP data that "holds" over time and, second, with the translation of that data into the Facility Development Plans. The Facility Development Plan is the interface between MEDIPP (medical program planning) and construction (facility development planning). All FDPs will be reviewed throughout their development by DM&S and are ultimately approved by the Chief Medical Director. They also will be periodically reviewed and updated, as necessary, to reflect changing medical program needs and priorities. Existing DM&S staff (Director of Operations, ACMDs, Regions, Districts and VAMCs) can perform this function without a duplicative, separate staff in DM&S. These DM&S entities would be reviewing FDPs anyway even if a FEPAC existed in DM&S.

The issue of retention of the "planning component" in DM&S reflects the possible confusion about the necessary, but distinct, roles (and different skills and talents) of program planning versus facility planning. On the one hand, the programmatic planning of the delivery of medical care is the sole responsibility of the Chief Medical Director. This includes the allocation of resources, what medical services to provide, the level of medical services needed and where, etc. Facility planning, on the other hand, is the process of planning facilities, whether it be by purchase, lease, renovation or new construction, which will meet the stated needs of the Department's program planners. The program planners must determine their priority of deficiencies and anticipated needs which must be addressed to continue to provide their stated and approved level of medical care delivery. In other words, the Chief Medical Director has the responsibility for centralized control of that program planning and its necessary prioritization among the various medical centers' stated needs; whereas, the centralized control for facilities planning is within the Office of Facilities. If this distinction can be appropriately understood, there is no legitimate purpose for a facility planning component within DM&S, just as there is no legitimate purpose for a medical program planning component in the Office of Facilities. The medical program planning process (MEDIPP) becomes linked with (and indeed drives) the facility planning process in the development of the FDPs.

b. Nonrecurring Maintenance and Repair Program

(1) The NRM (Nonrecurring Maintenance and Repair) funds are included in the medical care appropriation (0.23) for nonrecurring M&R (Maintenance and Repair), nonrecurring BSER (Building Service Equipment Replacement), BSEA (Building Service Equipment Additions) and MI (Minor Improvement); therefore, each should be properly identified on each project submittal. The types of work covered in each area are:

(a) M&R

1. Replacement of complete or major segments of utility systems, which include systems within a building.

2. Replacement of complete or major segments of building components such as doors, windows, flooring, floor covering and ceilings.

3. Replacement of major items of work on a building shell, such as roofing, tuckpointing and waterproofing.

4. Replacement of patient support and fire protection systems such as nurses call; AOV (air, oxygen and vacuum) sprinkler and fire alarm systems.

5. Maintenance work on roads, grounds, structures and exterior distribution systems, provided that the area involved is not scheduled for modernization or expansion.

(b) BSER. This category of maintenance is designed for the replacement of complete units of items which qualify for replacement when they can no longer be economically maintained. Replacement equipment should be planned to provide models embodying the most up-to-date technological advances and economic factors. Necessary action will be taken to insure that the value of items replaced be removed from the asset accounts and supporting records. Cost to update or improve existing utility service to the equipment should be identified as M&R.

(c) BSEA. This category of maintenance is designed for new building service equipment acquisitions and expanded capacity of existing equipment servicing a larger area or function. Installation costs for equipment will be restricted to charges for work necessary to put the equipment in place and make proper hookup to available utilities adjacent to the equipment. Costs of installing systems and utilities to and from the equipment or area adjacent to the equipment will be identified as MI (Minor Improvement).

(d) MI. Structural changes, space utilization changes, construction of additional or new space, and the installation of additional facilities and systems are classified as minor improvements. In projects for replacement of systems which include expansion to a new area, the cost related to the expansion will be considered a minor improvement. In projects that include A/E fees, a percentage of the A/E cost based on the percentage of minor improvement cost, as compared to total NRM funding (exclusive of A/E fees), will be considered minor improvement cost. Minor improvements will be planned as appropriate to provide specialized medical service projects, functional rearrangements and such additions and modifications as necessary to provide efficient and modern facilities. A project will not be fragmented into separate projects as a means of subverting the minor improvement dollar limitation. [illegible]

(2) There is no cost limitation on nonrecurring maintenance and repair work that can be accomplished in a nonrecurring maintenance project, provided that the total minor improvement portion of the project does not exceed ~~$50,000~~ $100,000 and the work is not scheduled for accomplishment within a minor or major construction project.

c. Construction Programs. A project that exceeds the cost limitation of the Nonrecurring Maintenance and Repair Program becomes a construction project. There are two programs for construction projects (Minor Construction (includes Minor Miscellaneous) and Major Construction), with the limitation of each being based on total construction cost (including fixed equipment). The total construction cost limitation for each program is:

(1) **Minor Program;**

Minor Miscellaneous	$ ~~50,000~~ 100,000 - $	400,000 500,000
Minor Construction	~~400,001~~ 500 -	2,000,000

(2) **Major Program:**

Over $2,000,000

d. Purchase and Hire (P&H) Projects. It is a general policy of the VA to accomplish projects by formal contract; however, in special cases to avoid continued interferences with normal hospital

Administration

1985 the confidential nature of VA budget material should not be disclosed in any form prior to being transmitted by the President

Medical Programs
Fiscal Year 1987
Volume II

February 1986

Office of Budget and
Finance (Controller)
[illegible]

7. Maintenance and repair and capital investment: Increase of $72,554,000

When the Veterans Administration (VA) was formed, it obtained many of its facilities by inheritance from other agencies. Additional medical facilities were constructed after World War II. Because the VA is now comprised of many buildings over 30 years old, maintenance needs are increasing dramatically. Past funding levels in the non-recurring maintenance and repair (M&R) program have not allowed the Agency to keep pace with the effects of deterioration and modifications required because of changes in methods of patient care, advances in modern technology, code requirements, Joint Commission on Accreditation of Hospitals (JCAH) standards and energy conservation retrofit projects. An additional influence on the program level and budget is the need to maintain and upgrade building service equipment components and utility systems as part of interior and exterior maintenance projects. It is imperative that aging VA facilities be maintained at a level where accreditation and patient safety are not compromised. The following chart provides a detailed analysis of the resources requested for capital investment in 1987. A discussion of the resource change for each category follows the chart.

SUMMARY OF RESOURCE INCREASES, SECTION 7
(dollars in thousands)

Program	1986 Estimate	1987 Estimate	Increase (+) Decrease (-)
a. Object class 31 equipment:			
(1) Replacement equipment:			
Existing facilities	$ 73,446	$ 71,801	$- 1,645
Construction projects	100,000	106,504	+ 6,504
Subtotal	173,446	178,305	+ 4,859
(2) Additional equipment:			
Existing facilities	42,466	69,294	+26,828
Advanced technology medical equipment sharing	10,000	...	-10,000
Education and training	2,000	2,000	...
Other program improvements	1,300	...	- 1,300
Construction projects	68,750	56,259	-12,491
Computerized systems	14,661	38,272	+23,611
Subtotal	139,177	165,825	+26,648
Total object class 31 equipment	312,623	344,130	+31,507
b. Object class 32 lands and structures:			
(1) Replacement building service equipment	23,977	26,140	+ 2,163
(2) Additional building service equipment	13,547	15,708	+ 2,161
(3) Minor improvements	24,670	27,983	+ 3,313
(4) Maintenance and repair (Capitalized)	37,776	57,096	+19,320
Total object class 32 equipment	99,970	126,927	+26,957
c. Maintenance and repair (M&R) (Non-capitalized)	71,800	79,903	+ 8,103
Total capital investment (including facility activations)	484,393	550,960	+66,567
Less: Capital investment for facility activations (see section 8):			
Replacement	-100,000	-106,504	- 6,504
Additional	- 70,000	- 57,509	+12,491
Total object 31 facility activations	-170,000	-164,013	+ 5,987
Total capital investment this section (excludes facility activations)	$314,393	$386,947	$+72,554

7.a. Object class 31 equipment program:

Object class 31 equipment program for the Medical care appropriation activities are identified in two categories: (a) replacement; and (b) additional. Object class 31 equipment is personal property of a durable nature which normally has a useful period of service of at least one year.

(1) Replacement equipment: Replacement equipment levels are determined in accordance with prescribed equipment life expectancy tables and use standards. These criteria require that equipment items be repaired, refinished or refurbished and continued in service as long as economically feasible. The majority of medical equipment should be replaced within 5 to 10 years after being placed in use. In 1987, $178,305,000 is the estimated level for replacement equipment. Of this amount, $106,504,000 is for facility activations (see section 8) and $71,801,000 is for existing facilities. This level will allow the Agency to meet 27.7 percent of the total 1987 equipment replacement estimate. The chart below highlights replacement equipment estimates for 1986 and 1987:

(dollars in thousands)

	1986 Estimate	1987 Estimate
Prior year backlog	$298,156	$369,813
Current year estimates	+245,103	+273,193
Total	543,259	643,006
Less: planned obligations	-173,446	-178,305
Total end of year backlog	$369,813	$464,701

(2) Additional equipment: Additional equipment is new equipment at existing medical centers (equipment for new facilities is included in section 8) and is comprised of: (1) equipment for existing medical centers; (2) equipment for education and training; (3) equipment for other program improvements; and (4) equipment for computerized systems. In 1987, $165,825,000 is requested for additional equipment. Of this amount $57,509,000 is for facility activations (see section 8), with the remaining $108,316,000 to be utilized as follows:

(a) $69,294,000 will be utilized for purchasing additional equipment at existing medical centers (VAMC's). This estimate is based upon the need to equip VAMC's concurrent with the implementation of new medical and administrative technology. This funding level will provide limited improvements in the utilization of equipment at existing VAMC's involving functional areas related to the care and treatment of patients. In addition, any analysis of funding levels for replacement and additional equipment must consider the fact that although a piece of equipment may replace another piece of equipment, if the new equipment performs an additional task it is considered additional equipment. Included in this section are resources for the purchase and installation of telephone systems.

(b) Current estimates indicate the additional equipment level for education and training facilities will remain at $2,000,000 in 1987. Equipment in this category includes conference and training equipment at VA Regional Medical Education Centers (RMEC's); patient education programs; microfilm readers/printers to support shared journal acquisition programs; and continuation of the video-notebooking capability recommended by the VA Inspector General.

(c) In 1987, $38,272,000 is requested to support computerized systems equipment acquisitions. This request level is composed of a recurring base of $2,004,000 and includes $1,250,000 to support automated data processing (ADP) equipment acquisitions for facility activations (included in Section 8).

In 1986, capital accounts included $10,000,000 for advanced technology medical equipment sharing (for equipment in excess of $500,000). This pilot program was restricted to VA facilities where other non-federal sources commit to financing at least 50 percent of the acquisition costs. Also included in the 1986 capital accounts was $1,300,000 for other program improvements. In 1987, these 1986 non-recurring purchases have been reduced from the base.

7.b. Object class 32 - lands and structures:

Equipment in this section includes pieces of operating equipment permanently installed in, or attached to, buildings and structures (real property) that make the building safe and suitable for occupancy. A total of $126,927,000 is requested in 1987 as describe below:

(1) Replacement building service equipment: In 1987, $26,140,000 is requested for replacement equipment. Equipment in this category is used to replace items of like capacity and usefulness including boiler plants; electrical and air conditioning equipment; elevators; emergency power generators; pumps; water heaters; etc. This funding level will allow the Agency to meet 13.7 percent of the total 1987 replacement equipment level. The chart below provides an overview of this program:

(dollars in thousands)

	1986 Estimate	1987 Estimate
Prior year backlog........................	$ 119,477	$ 139,833
Current year estimates....................	+ 44,333	+ 51,500
Total.....................................	163,810	191,333
Less: Planned obligations.................	- 23,977	- 26,140
Total end of year backlog.................	$ 139,833	$ 165,193

(2) Additional building service equipment: Program levels are based on central office review of individual center requests for additional building service equipment items. Improved aseptic and housekeeping techniques require installation of additional sinks, temperature controls, and hot water generators. Increased use of electro-medical equipment requires expansion of electrical systems with manual and automatic controls as well as air conditioning and ventilation equipment, especially at older centers. The 1987 request is $15,708,000.

(3) Minor improvements: The minor improvement program provides for structural changes, additional space, new or expanded utilities, or alterations, modernizations and space utilization changes to buildings, structures or grounds where the improvement costs for each project are less than $100,000. This includes station labor when used, but excludes the cost of installed equipment. A funding level of $27,983,000 in 1987 will provide for the completion of high priority minor improvement projects. This funding level will support the installation of additional equipment and improvements needed to correct code and criteria deficiencies.

(4) Maintenance and repair (M&R) (capitalized): Capitalized M&R projects replace major segments of: interior and exterior utility systems; individual building components (windows, doors, etc.); and patient support and protection systems (sprinkler, air-oxygen, vacuum, etc.). This work adds to the value and extends the useful life of the structure. Because of the number of aging facilities, these projects in many cases are necessary to correct code and "critical operational" deficiencies. The 1987 estimated level for M&R is $57,096,000.

7.c. Maintenance and repair (non-capitalized):

Non-capitalized M&R work is of a sustaining nature to prevent or offset the physical deterioration of real property. Funding for these projects is estimated at $79,903,000 in 1987. These projects do not add to the value of the real property but are necessary to maintain facilities at existing levels.

DISABLED AMERICAN VETERANS' RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY THE HONORABLE FRANK H. MURKOWSKI, CHAIRMAN OF SENATE VETERANS' AFFAIRS COMMITTEE

QUESTION 1:

In light of budget restraints and the tremendous cost of building a new hospital, why do you oppose the VA's purchasing or leasing existing facilities? Aren't you, in fact, choosing to limit access instead of promoting greater access to VA medical care?

ANSWER 1:

The DAV does not, nor have we ever, opposed the concept of the Veterans Administration purchasing or leasing existing medical facilities. Conversely, we embrace, in theory, the concept of the VA acquiring facilities when, and only when, it is clearly documented that a need exists in a particular geographical area in order to best meet the needs of the disabled veteran population. We do not favor, however, the arbitrary purchase, by the VA, of medical facilities simply because they may be available. Additionally, as the VA has the authority to purchase or lease existing facilities we do not favor enactment of legislation that would mandate them to do so. We do not view government, particularly the VA, as an entity to ease the burden of the private health care industry who, has grossly overbuilt that sector of health care by the creation of medical facilities that are, in many cases, grossly underutilized.

QUESTION 2:

Would you generally support the VA's use of private sector health care services if the demand on the VA could be eased and additional options for care made available to veterans?

ANSWER 2:

The VA currently utilizes private sector health care services in a variety of circumstances including, community nursing homes, the fee basis program and utilization of their authority to enter into agreements with various medical facilities and schools. These programs are sometimes found necessary and desirable based on such things as geographical consideration and the scarcity of specialized medical resources. The DAV cannot and will not support the VA's use of private sector health care services simply as a mechanism to diminish the Agency's role and function of providing medical care to disabled veterans. Nor, can we support any proposal that serves as a method to bolster the private sector's sagging hospital utilization rate. In our view, we are being asked to support the disturbing and totally unacceptable notion of "mainstreaming" or "privatization" of the VA health care system. We vehemently oppose any such proposal.

QUESTION 3:

What are you views on the idea that the VA work with other federal agencies and the private sector to develop a comprehensive long-term care policy involving VA care, Medicare, Medicaid, private health insurance, tax incentives and other initiatives?

ANSWER 3:

The VA is extensively involved in working with other federal agencies and the private sector to develop not only long-term care policy but policy as it effects the delivery of health care in general. The White House Working Group on Health Policy and Economics, Special Medical Advisory Group (SMAG), Medical Advisory Consortium (MAC) and the various Congressionally mandated and agency initiated advisory committees are a few illustrations. VA's participation in these groups and committees are certainly beneficial and we can support the continuance of the Agency's involvement as the debate regarding the country's health care policy continues. We feel that the VA's involvement in such activities assists the Agency in molding their policy of providing health care. Additionally, the VA's experience and expertise in this area can only prove beneficial to the private sector in attempting to develop, what we feel has been, heretofore, a virtual nonexistent or poorly conceived long-term care policy. We do not support however, the absorption of providing long-term care to veterans into the private sector as we believe they are ill equipped to provide such care to eligible veterans.

WRITTEN QUESTIONS FOR THE MARYLAND CHAMBER OF COMMERCE
FROM SENATOR FRANK H. MURKOWSKI
REGARDING THE HEARING OF THE COMMITTEE ON VETERANS' AFFAIRS
ON VA MEDICAL FACILITY CONSTRUCTION, APRIL 10, 1986

1. How do you respond to the concern that the VA would be "bailing out" the private sector by using excess private sector beds?

2. Building a VA hospital would appear to benefit Baltimore's economy. As representatives of business organizations, why won't the additional jobs generated by this project cause you to support it?

3. What plans are there to convert Maryland's excess hospital beds to long-term care beds to meet the needs of the aging population?

4. Other than the key card approach discussed in your testimony, what leasing or purchasing options exist within Baltimore?

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ENVIRONMENTAL
ELEMENTS
CORPORATION

Richard E. Hug
President and Chief Executive Officer

May 2, 1986

The Honorable Frank H. Murkowski
United States Senate
Chairman, Committee on Veterans' Affairs
414 Senate Russell Office Building
Washington, D. C. 20510

Dear Senator Murkowski:

Thank you for your letter of April 18, wherein you requested answers to additional questions regarding the hearing of the Committee on Veterans' Affairs on VA medical facility construction - April 10, 1986.

o The VA would not be "bailing out" the private sector by using excess private sector beds. The excess beds are not a private sector problem, but rather a community and taxpayer problem. The State of Maryland is overbedded by some 5,000 beds, half of which are in the City of Baltimore. This excess "unused" capacity has a major impact on health care costs in Maryland, with the cost of an unused bed ranging between $20,000 to $100,000 per year depending upon the kind of bed (medical, surgical pediatric), as well as the staffing, intensity and hospital debt situation, etc. This cost is currently being borne by our citizens through the rates established for health care by the Maryland Health Services Cost Review Commission.

o Building a VA hospital would certainly benefit Baltimore's economy. This benefit, however, would be only short-lived - for in the long term, the overbedding condition would be seriously exacerbated by yet another hospital. The moneys that would be used to construct such a facility could better be used in other areas which offer superior returns.

o Plans are being made to convert Maryland's excess hospital beds to long-term beds, and a report from the Maryland Health Resource Planning Commission to the state legislature is due shortly. That report which has not been made public would contain the definitive response to the questions about plans to convert existing Maryland acute care beds to long-term care. Informally, we have learned of about 5 hospitals that have declared their intention to convert about 260 beds to long-term care use.

- Other than the key card approach discussed in our testimony, leasing or purchasing options certainly exist in Baltimore. The question of available beds for lease or purchase naturally is politically sensitive. There is presently a hospital in Baltimore whose future is clouded by receivership and stringent state government-imposed guidelines for recovery. We would urge the VA to discuss the issue with Governor Harry Hughes and his staff, and the staff and leadership of the Health Resources Planning Commission.

Once again I convey our thanks to your Committee for considering this matter and showing a strong sense of federal fiscal responsibility. Now certainly is not the time to be spending financial resources that we do not have because of a mounting federal deficit for a project that is not needed in light of the over-abundance of existing unused hospital beds not only in Maryland, but throughout the Nation. Your Committee's action "can make the difference" on this issue which could be the beginning of our seeking a more cost-effective and accessible means of caring for the veteran population.

Sincerely yours,

Richard E. Hug

REH:nc

PARALYZED VETERANS OF AMERICA's ANSWERS TO SENATOR FRANK H. MURKOWSKI's QUESTIONS REGARDING THE APRIL 10 SENATE VETERANS' AFFAIRS COMMITTEE HEARING ON VA MEDICAL FACILITY CONSTRUCTION

Q. 1. Would your members support paid parking at VA facilities?

A. PVA does not support pay parking at Veterans Administration facilities for our Nation's veterans. This is not to say that the concept of pay parking at VA facilities should not be explored. PVA believes that any efforts to charge veterans for parking would prove to be totally incompatible with the mission of the VA. In a society almost wholly dependent on the automobile for transportation, parking is an integral part of access to the VA health-care system. With the absence of mainline, accessible mass transit in most areas, the privately owned vehicle is indispensable for access to the system for both veterans and employees alike. Additionally, with collocation of VA medical centers and regional offices being considered for expanded utilization, the implementation of pay parking would further serve to restrict access to the full range of veterans' benefits and services. In light of current budget constraints, it has become apparent that the funding for the construction of new parking facilities is being viewed as a low priority, and that alternative funding needs to be examined. PVA recognizes the need to explore alternate methods of funding, and we would encourage the Committee to examine the use of the revolving fund approach as a possible solution to this dilemma. PVA would like to express an ongoing interest in helping to resolve this issue.

Q. 2. In light of budget restraints and the tremendous cost of building a new hospital, would you support the VA's purchasing or leasing existing facilities? Do you believe this would promote greater access to VA medical care?

A. PVA is under the impression that the VA examines, wherever possible, available hospital buildings for sale in the particular area. The invariable finding has been that most existing facilities are obsolete and would prove more costly to renovate than would be cost of new construction. Such facilities are frequently available, because the private hospital has abandoned them in favor of new construction. An alternative to acquisition or construction is the possible leasing of a section of a modern and privately operated facility by the VA. This could increase access to VA medical care. It is imperative, however, that such a leased facility be administered and staffed by VA personnel.

Q. 3. Would you generally support the VA's use of private sector health-care services if the demand on the VA could be eased and additional options for care made available to veterans?

A. PVA is opposed to what is euphemistically referred to in the private sector as "mainstreaming." The VA has for some time purchased private medical care for its patients. PVA would have no objection seeing that percentage increased as long as it remains under the control of the VA Department of Medicine and Surgery, so that the patient mix is not so disturbed as to damage teaching affiliations, and compromise the recruitment of high quality VA health professionals.

Q. 4. What are your views of the idea that the VA work with other federal agencies and the private sector to develop a comprehensive long-term care policy involving VA care, Medicare, Medicaid, private health insurance, tax incentives, and other initiatives?

A. This is an idea whose time is over due. PVA would not only support it, but wishes very much to be involved in it. PVA has taken every opportunity to promote this very concept. It is important to emphasize PVA's opposition to the concept of "mainstreaming" which is applicable to acute care and long-term care as well. It is essential that the VA utilize all available resources and examine all appropriate models when planning long term care policy, so long as the actual implementation of veterans' health care programs remain under the control of the Veterans Administration's Department of Medicine and Surgery.

WRITTEN QUESTIONS FOR THE AMERICAN LEGION FROM SENATOR FRANK H. MURKOWSKI REGARDING APRIL 10 SENATE VETERANS' AFFAIRS COMMITTEE HEARING ON VA MEDICAL FACILITY CONSTRUCTION

1. In your testimony, you said that you oppose reliance on community nursing homes because they are not subject to constant quality assurance examinations. Do you believe there is a problem with the quality of care provided to veterans in community nursing homes?

2. In light of budget restraints and the tremendous cost of building a new hospital, why do you oppose the VA's purchasing or leasing existing facilities? Aren't you, in fact, choosing to limit access instead of promoting greater access to VA medical care?

3. Would you generally support the VA's use of private sector health-care services if the demand on the VA could be eased and additional options for care made available to veterans?

4. What are your views of the idea that the VA work with other federal agencies and the private sector to develop a comprehensive long-term care policy involving VA care, Medicare, Medicaid, private health insurance, tax incentives, and other initiatives?

The American Legion
For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
(202) 861-2700 ★

April 29 , 1986

Honorable Frank H. Murkowski, Chairman
Senate Veterans Affairs Committee
SR-414 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Murkowski:

This letter is in response to your follow-up questions arising from the Committee's hearing of April 10, 1986. In your first question we are asked whether we believe there is a problem with the quality of care provided to veterans in community nursing homes. The question is predicated on our presumed opposition to reliance on community nursing homes, given their freedom from the same quality assurance standards as imposed on VA nursing homes.

As you will recall, our statement noted that we oppose increased reliance on private sector community nursing homes as intended by the VA/OMB proposal to change the formula for addressing extended health care needs of veterans. The current formula of providing 40 percent of care through VA, 40 percent through state homes and 20 percent through the private sector would be changed by reducing VA provided care by 10 percent and increasing private sector care by 10 percent. It is this increased reliance on the private sector to which The American Legion objects. In fact pages 2 and 3 of our statement are rather explicit when it is pointed out, "We do not disagree that community nursing homes play an important role in VA's effort to provide nursing care to veterans. However, there are certain postualtes that must be taken into consideration." To reiterate the points made in our statement, veterans are all too often in need of care so specialized as to make their acceptance in private sector facilities unlikely and private sector facilities are too few across the country to justify increased reliance on them at the present time.

Your second question asks whether or not, by reason of opposition to VA purchase or lease of existing facilities, we are choosing to limit veteran access instead of promoting greater access to VA medical care. As with the first question, we are mistakenly assumed to have taken a position of categorical opposition to VA acquisition of existing facilities. Though we are highly inclined against such acquisitions as pointed out in our statement, there may be "instances in which a private facility would meet the needs and requirements necessary to establish a VA medical center or outpatient clinic, in which case we would reserve judgment until every aspect of the situation was thoroughly reviewed."

Our current inclination, however, is based on the fact that most private sector facilities are built to standards inferior to those of VA. For example, as Chief Medical Director Ditzler stated at the hearing, private sector hospitals are built to last 20 years while VA hospitals are built to last 40 years. Given the slow process of VA's renovation and replacement program, this is a wise policy. Apart from this however, it would be unwise indeed for VA to acquire a facility having reached or exceeded its expected period of usefulness. To do so would likely guarantee costly repairs.

Your third question seeks our position on providing private care services if the demand on VA could be eased and additional options could be made available to veterans. This question appears to assume that we oppose private medical treatment for veterans. We don't, but we are concerned over a decelerated schedule of VA medical facility replacement and the administration's apparent desire to discontinue VA nursing home construction.

Private care, whether contracted through community nursing homes or provided individually on a fee basis, is currently being offered to veterans. The American Legion clearly recognizes that nonavailability of VA services in certain localities or a scarcity of VA treatment specialties demand some reliance upon private medicine. However, expansion of this approach through general "vouchering" or some similar method (1) would offer no guarantee of priority care for veterans, and (2) would not likely be an economical alternative, given the pace of private medical cost increases over recent years.

Supplying more private care to veterans might ease the burden on VA's treatment capabilities, but if such care was authorized by VA it certainly would not ease VA's budgetary burden. We are also not convinced that private care services would offer additional options to veterans. If your reference to "options" means treatment modalities, we must state our belief that recent legislative authority and contemplated changes now provide or will provide a reasonable array of alternative techniques within VA. Certainly, where private medical services are available (and not available through VA) then contracting for those services, on a case-by-case basis, is a legitimate option.

The American Legion is well aware of regions in this country where veteran patient demands do not warrant a VA medical facility, and in those areas private medical services must be called upon to meet the medical needs of veterans. These regions, some situated in your home state of Alaska, present a special set of veteran patient demographics; however, those conditions cannot be generalized to offer a representative sampling of veterans nationwide. In our opinion, most acute and long term care needs must be met by treatment provided in VA facilities. Where sound medical practices and geographic circumstances dictate, private resources may be used to complement or augment VA services.

In response to your fourth question regarding VA's cooperation with other federal agencies to develop a comprehensive long-term care policy, we firmly believe that VA must consult with other public and private health care entities if a realistic policy is to be established and implemented. In fact, VA is already engaged in cooperative health policy relationships. Examples include information sharing with the Department of Health and Human Services regarding non-institutional care (as required by the Older American Act), information sharing and research work with public and private sources as part of VA's geriatric program, and facility/resource sharing with the Department of Defense.

It's obvious that decisions on Medicare and Medicaid either directly or indirectly impact on VA health care delivery. The recent enactment of means test authority, including its co-payment provision tied to Medicare, makes that connection rather apparent. Medicaid decisions often affect the operation of state veterans homes, especially if VA per diem payments tc those homes are "pooled" with Medicaid funds for subsequent distribution to nursing homes, both veteran and non-veteran facilities.

One of the more available options to minimize the future cost of long-term health care involves the use of volunteers. Of course, volunteers will continue to be necessary to man the VAVS Program, to provide transportation and other services for persons who do not require nursing home care, and to provide supportive services to long-term care facilities. We believe, therefore, that the nation's income tax policy should encourage such volunteer activities, particularly at a time when the number of able-bodied retired Americans is increasing dramatically -- persons who are prime volunteer candidates. Tax policy changes might also be considered to encourage family members of veterans to assume additional long-term care responsibilities in their own homes.

The matter of public and private sector cooperation to develop sound health policy is specifically addressed in the recently-enacted Fiscal Year 1986 budget reconciliation measure. That law calls for the creation of a task force composed of public officials, private insurers, and representatives of health care consumers. We have already expressed our views to the Secretary of Health and Human Services that task force membership be offered to the Veterans Administration and the veterans community.

Our thoughts on public/private sector exchange clearly accommodate the view that VA long term care must be practiced with full recognition and understanding of other delivery systems. However, these thoughts are also based upon an insistence that VA's health care delivery system be maintained as a separate and distinct treatment mechanism.

Sincerely,

E Philip Riggin

E. Philip Riggin, Director
National Legislative Commission

WRITTEN QUESTIONS FROM CHAIRMAN MURKOWSKI TO THE VETERANS' ADMINISTRATION AND THE RESPONSES

Question: 1. You are clearly faced with the challenge of meeting the long-term care needs of older veterans. In the past, despite the availability of community hospital beds in certain locations, the VA continued to support building replacement hospitals. Has the VA's policy changed regarding the approach to this issue? If so, in what ways?

Answer: The Va has not changed its policy with respect to the need for modern facilities. In the past, when community facilities were available for acquisition, it was most always because the facility had outlived its usefulness as a hospital and was being abandoned by the community provider. The VA has historically been offered hospitals which were totally inadequate. Today, given the many changes in the delivery and financing of health care in the private sector, it is possible that a hospital with continued usefulness will be offered for sale.

Recognizing this, the VA has adopted a policy of considering the potential for lease or purchase of an existing medical facility as an alternative to construction of a new or replacement VA medical center. We are currently finalizing procedures to implement this policy. These procedures will include a public solicitation early in the planning process for new or replacement facilities. If an existing facility is available for acquisition and, based on a preliminary examination, appears to have potential to meet VA needs, a detailed economic cost analysis will be conducted to compare the costs of acquisition versus VA construction.

Question: 2. How would the etablishment of "Centers of Excellence" for various specialities, such as cardiac surgery, affect construction planning?

Answer: The establishment of "Centers of Excellence" such as cardiac surgery would have minor impact on construction planning in most cases. These special programs are for the most part, in existence in our tertiary care facilities which currently act as the referral center for other VAMC's in the district.

Question: 3. The law requires the VA to maintain 90,000 hospital and nursing home beds. The intent of Congress was to ensure a minimum level of patient care. However, in 1985 thirty-five VA hospitals had occupancy rates below 65%. With changes in medical-care technology and treatment methods, does this well-intentioned law tie the VA's hands instead of adding to its operating capabilities?

a. Is it an inefficient use of resources to maintain the 90,000 bed level?

b. In order to provide medical center directors with more flexibility in allocating resources, do you believe it would be more appropriate to define beds to include bed equivalents and/or episodes of care?

c. If you had the authority to conduct a pilot program at a few selected medical centers to allow medical center directors to allocate resources without being subject to staffing and bed requirements, would you exercise this authority and if so, why? How would you structure such a pilot program? What requirements would you continue to maintain?

Answer: This well intentioned law does not recognize that there are other modes of care available for treating the patient other than VA hospital based-care. For example, the provision of outpatient care has had and continues to have, an increasingly important role in fulfilling the Department's primary function as a comprehensive medical and hospital service. In addition, the VA has found that increased use of community and state nursing homes is an efficient use of scarce medical resources. The VA must be allowed to continue to operate in the most cost effective manner while at the same time meeting the needs of eligible veterans, irrespective of the bed levels needed to accomplish this. Improved utilization of these as well as other non-VA bed-oriented treatment modalities has enabled the VA to provide more care with fewer beds. In 1980, for example, the VA operated 84,129 hospital beds with 1,247,516 patients treated and 15,751,690 outpatient visits; in 1985 on the other hand, the VA operated 74,357 hospital beds with 1,350,702 patients treated and 17,789,582 outpatient visits.

In other words, with 7 percent fewer beds, the VA treated 8 percent more inpatients and 11 percent more outpatients.

Question: 3.a. **Is it an inefficient use of resources to maintain the 90,000 bed level?**

Answer: The VA is efficient in the use of its resources since VA hospitals are staffed and funded on the basis of workload experienced and not on the number of available beds. Therefore, occupancy rates are not good indicators of the systems efficiency and resources expended.

Question: 3.b. **In order to provide medical center directors with more flexibility in allocating resources, do you believe it would be more appropriate to define beds to include bed equivalents and/or episodes of care?**

Answer: Bed equivalents are defined as:

Patient Days of care divided by 365 days (this equates to ADC) divided by an ideal occupancy rate (usually 85%).

Episodes of care are defined as:

The length of stay needed to provide the required hospital care.

Today, medical center directors are provided maximum flexibility in allocating resources through the use of a Resource Allocation Methodology which is based on casemix and DRGs as well as episodes of care.

Bed equivalents is a useful concept for bed sizing but as indicated above not so for resource allocation.

Question: 3.c. The law requires the VA to maintain 90,000 hospital and nursing home beds. The intent of Congress was to ensure a minimum level of patient care. However, in 1985 thirty-five VA hospitals had occupancy rates below 65% .... If you had the authority to conduct a pilot program at a few selected medical centers to allow medical center directors to allocate resources without being subject to staffing and bed requirements, would you exercise this authority and if so, why? How would you structure such a pilot program? What requirements would you continue to maintain?

Answer: We would exercise authority to allocate resources without being subject to staffing and bed requirements in order to achieve a greater measure of efficiency and effectiveness in utilizing VA resources and management skills. Placement of the broadest possible authority with local management would contribute to accomplishment of the Agency's mission. As currently envisioned, a cross section of five VA medical centers to be chosen for the pilot program would participate for a minimum of three consecutive fiscal years. This would provide a meaningful opportunity to implement change and see measurable results. Evaluation of the program would focus on performance measures such as VA and non-VA workload, unit costs, timeliness of services, and range of services. Examples of changes in the operating environment being considered, in whole or in part, for the five facilities chosen to participate in the pilot program, include, but would not be limited to, the following:

-- Eliminate grade and special pay rate restrictions.

-- Liberalize operating and authorized bed floors, and relax requirements for bed service and section mix within the current overall total.

-- Provide no-year funding within the annual appropriation for test facilities.

-- Eliminate funding limitations on employee travel and personal services.

-- Eliminate all other limitations, restrictions, ceilings, floors, and constraints on funding other than on the overall availability of funds.

-- Eliminate funding limitations on ADP.

-- Suspend the requirement for mandatory participation of test facilities in proposed A-76 studies.

-- Relax GS/GM 11-15 hiring restrictions and review other restrictions internal to the Agency.

-- Constraints imposed by overall availability of funds.

-- The current primary missions of chosen facilities.

We anticipate the maintenance of procurement requirements.

Question: 4. The General Accounting Office testimony noted that the Booz Allen Report stated that the VA's Medical District Planning Process "did not produce a national health care strategy with a set of clear medical care priorities to guide construction planning and priority setting". Do you agree with this assessment? If not, why not?

Answer: The Veterans Administration does not totally agree with this assessment. VA's Construction program request is based on programmatic requirements developed in our Medical District Initiated Program Planning (MEDIPP) process. In this process top down planning guidance is issued. This guidance emphasizes high priority areas which must be addressed by local planning boards. Plans developed locally are prioritized and reviewed at the district, regional, and VA Central Office levels. After the MEDIPP proposals are approved, they are then prioritized for inclusion in Medical Care budgets and form an important part of another prioritization process for construction projects. The recently developed construction prioritization methodology is based on these expressed program priorities as well as other factors such as functionality and physical deficiencies. However, the VA generally agrees with the Booz Allen core process recommendations and believes, once implemented, that these will further enhance our ability to guide construction planning and priority setting.

Question: 5a. If the VA had a paid parking policy, what would such a policy emphasize?

Answer: We are studying several options which would establish a paid parking program.

Question: 5b. Who should pay and who should not?

Answer: That decision is contingent upon which of the several options is adopted.

Question: 5c. Where should the proceeds go?

Answer: We would favor depositing any parking fees that may be collected into the miscellaneous receipts of the Treasury.

Question: 5d. Which hospitals -- existing, new, planned -- should implement paid parking?

Answer: That decision is contingent upon which of the several options is adopted.

Question: 5e. Would the policy apply to surface parking and parking garages and facilities?

Answer: That decision is contingent upon which of the several options is adopted.

Question: 6. What are the findings of the VA site team that reviewed the West Los Angeles and Sepulveda excess land proposals?

a. What are the team's recommendations and do they differ from those of the General Services Administration?

Answer: The purpose of the site team visit was to ensure that all relevant factors were identified and considered in the land excessing decision process. The report forwarded to the Administrator those factors which the site team considered important and information to assist the Administrator in evaluating the land excessing proposal. When the report has been finalized, a copy will be provided to the Committee.

Question: 7. When will you finish your review of the proposal to reorganize the VA Central Office Construction Staff?

Answer: On February 5, 1986, the VA submitted to the Congress a "detailed plan and justification" for the construction reorganization consistent with the requirements of 38 U.S.C. 210(b). Administrator Turnage is currently reviewing this proposal from several perspectives including: the Department of Medicine and Surgery, the Office of Construction, and the Booz, Allen and Hamilton/RTKL Associates, Inc. consultant report. The final briefing on this subject was presented to the Administrator on May 13, 1986. The Administrator hopes to complete his review of the proposed construction reorganization in the near future and will report his decisions to the Committee.

Question: 7a. What plans do you have to improve the construction planning process as well as the organizational structure?

Answer: The Booz, Allen and Hamilton/RTKL study recommended several changes to the VA's process and procedures for planning and execution of the construction program. These recommendations which are known as the "Core Process Recommendations" have been generally agreed to by VA and are being reviewed to determine the manner and extent of VA implementation. These recommendations relate to improving facility plans, development of an information data base, linkage with medical program planning, modification to the design process, and improved process standards and control tools. Administrator Turnage has directed that implementation of these recommended procedural improvements be given top priority.

Question: 7b The VAMC in Loma Linda was built less than 10 years ago. Now there seems to be 300 excess beds in Southern California and conversion from acute care to long-term care beds is being considered. The new VAMC in Albuquerque is also projected to have a sufficient number of excess beds to enable the VA to enter into a sharing agreement with the Air Force. What process changes do you plan to implement to prevent such situations from arising in the future?

Answer: The construction projects which created the current bed levels at the Loma Linda, California and Albuquerque, New Mexico VA Medical Centers were developed at a time when VA length of stay was substantially higher than the community's and the facilities were built to support that higher level. Since that time, the VA has made great strides in emulating the community's length of stay experience by developing alternatives to inpatient care and implementing a Diagnosis Related Groups (DRG) funding allocation model. These actions have resulted in substantially reduced VA lengths of stay. The bed projection model considers these improvements in developing future bed needs; and these future bed needs are then used to establish the size and scope of major construction projects. These improvements have been made to ensure that the VA does not "overbuild" in its construction program in the future. Bed projections will be monitored to make sure any further reductions in lengths of stay are reflected in construction planning.

Question: 8. In a letter I sent to the Budget Committee, I recommended an additional $35 million for major construction for Fiscal Year 1987. If you were provided with these additional funds, how would you use them?

Answer: If the Congress were to see fit to provide the VA with an additional $35 million for major construction, we would closely look at our needs and make selections consistent with our prioritization methodology and Administration policies.

Question: 9. During the hearing, Dr. Ditzler stated that occupancy rates do not reflect the number of beds available for occupancy. Why, in determining occupancy rates, does the VA not take into account such factors?

Answer: Historically, the definition of the bed occupancy rate is:

$$\frac{\text{Number of patient days of care for period}}{\text{Beds available x number of days in period}}$$

Every hospital (VA and non-VA) counts the total number of beds that they have available such as medical, surgical, ICU, etc.

From a practical point of view, if you have a two-patient room with a female occupying one bed, the other bed in the room is unavailable to a male patient. However, this unavailable bed is counted as empty in the official definition. Likewise, if a patient needs to be in isolation and occupies a two-bed room, the other bed is not available to a patient and is listed as empty, reducing the occupancy rate.

In addition, ICU beds are used when medically needed. If a patient needs admission to the hospital but does not need an ICU bed and there are no non-intensive beds available, this patient cannot be admitted. The above definition, however, would indicate that there might be sufficient beds available.

The National Health Planning and Resource Development Acts of 1974 to the present have focused considerable attention on the over-bedding dilemma in the private sector. The VA has similar problems which are shared by DoD. Contingency planning for national emergency and back-up situations require the VA to have sufficient beds available which are not normally occupied, but are included in the bed count. For this reason the VA occupancy rate is consistently skewed less than the actual numbers of beds available. Our MEDIPP plans reflect this fact and contain considerable narrative on the subject.

WRITTEN QUESTIONS FROM CHAIRMAN MURKOWSKI TO THE VETERANS OF FOREIGN WARS OF THE UNITED STATES AND THE RESPONSES

Question #1 - In light of budget restraints and the tremendous cost of building a new hospital, why do you oppose the VA's purchasing or leasing existing facilities? Aren't you, in fact, choosing to limit access instead of promoting greater access to VA medical care?

Response #1 - The VFW would not object to purchasing existing private sector health facilities so long as they are cost-effective, meet VA construction standards and are located according to need and not political expediency. It is our understanding that although the VA has investigated this option, no such suitable facilities have been found. With respect to leasing private sector facilities, the VFW would only find this option acceptable in those instances where it would be impractical to build such a facility due to demographic considerations and when such a facility would meet the VA medical care standard. VFW Resolution #717 entitled "Veterans' Health Care" calls for increasing VA health care facilities to provide long and short term care due to the increasing needs of the aging and younger veterans. We are convinced that only the adequate funding of the VA construction program will truly provide greater access to medical care for veterans.

Question #2 - Would you generally support the VA's use of private sector health-care services if the demand on the VA could be eased and additional options for care made available to veterans?

Response #2 - Inasmuch as we strongly hold that the VA and not the private sector should take care of veterans in their time of need, the VFW is generally opposed to the VA utilizing private sector health-care services. Additionally, VA reliance on private sector health-care services could lead to the wholesale privatization of veterans' health care, and eventually undermine this Nation's largest integrated health-care system. Thus, the VFW only supports utilizing private sector health-care services when such services are absolutely unavailable within the VA health-care system or when such services are geographically inaccessible to a veteran.

Question #3 - What are your views of the idea that the VA work with other federal agencies and the private sector to develop a comprehensive long-term care policy involving VA care, Medicare, Medicaid, private health insurance, tax incentives, and other initiatives?

Response #3 - The VFW vigorously opposes any consolidation or co-mingling of the VA health-care system with nonmilitary related health-care systems. It is our goal to preserve high-quality VA hospital and medical care for veterans. Including the VA hospital system with systems not related to military service would, in our opinion, destroy the VA's special medical care programs which are specifically designed for those who have rendered a very special service to our great Nation.

WRITTEN QUESTIONS FROM SENATOR CRANSTON TO THE VETERANS' ADMINISTRATION AND THE RESPONSES

Question: 1a. In response to a question I posed prior to the Committee's February 25 hearing on the VA's fiscal year 1987 budget regarding the sizing methods applied to the four major replacement/modernization projects proposed in the FY 1987 budget request, the VA stated that the number of beds planned for Augusta, Dayton, and North Chicago was reduced slightly because of the significant observed reductions in the VA's length of stay that have occurred since the sizes of these projects were initially determined. Please provide a detailed analysis demonstrating specifically the extent to which reductions in the length of stay justified the reduction in the number of beds.

Answer: Bed requirements are directly and linearly proportional to length of stay (LOS). If LOS declines by 10%, bed requirements also decline by 10%. The reductions in the construction project bed levels reflect the observed 6.5% systemwide reductions in LOS between FY 1983 and FY 1985.

Question: b. The response to that question further indicated that average occupancy rates "are estimated to decline" by more than nine percent since these projects were initially planned. Please describe what changes were made as a result of this estimate and provide an analysis showing the extent to which occupancy rate changes justified any such changes in the sizing of these facilities.

Answer: Occupancy rates move in the same direction as length of stay (LOS). The declining occupancy rates are caused by declining LOS which is in turn caused by the impact of DRG-based resource allocation. The occupancy rates may in fact decline by 9% at some existing facilities. However, the bed sizing model applies standard occupancy rates (85% for acute bed sections and 95% for non-acute bed sections) to determine future bed requirements. These standard occupancy rates are used in lieu of actual, today, rates because the use of actual rates would require more beds to be built. It is also inefficient to build to a lower occupancy rate because there would be empty beds as a result and larger facilities would be needed. For example; if there is a projection of 600 patients on a daily basis a facility of 706 beds would be built if 85% occupancy is used. These same 600 patients would require 857 beds at a 70% occupancy rate.

Question: 2. Prior to the Committee's hearing on the VA's FY 1987 budget request, I had requested a listing of the 20 projects identified for funding in FY 1987 in the VA's December 1985 Five-Year Medical Facility Construction Needs Assessment according to the prioritization methodology recently developed by the VA and, to the extent that the VA's construction request for FY 1987 does not reflect this prioritization, I requested an explanation and justification for the changes.

The VA's March 6 response indicated that the FY 1987 construction budget request was arrived at using the prioritization methodology in conjunction with policy decisions made as part of the budget process. Thus, despite the fact that the Knoxville, Iowa, Laundry Replacement project appears 11th on the prioritized listing, it was not proposed for funding pending the completion of an A-76 study to determine whether replacement and VA operation of a laundry is more cost effective than private services. Also, although I don't necessarily agree with the reasoning given, the response also addressed why, contrary to the results that the priority methodology alone would have produced, four nursing home projects and land acquistion for a new facility in Palm Beach, Florida, were not included in the budget and a fire and safety and patient environment project in Waco Texas, was included.

However, the response to that question failed to provide any justification or explanation for why projects in Huntington, West Virginia, Salt Lake City, Pittsburgh, New York and Atlanta were not included in the Administration's request. What are the justifications in each case for not including those projects in the FY 1987 budget although projects of lower priority are included?

Answer: The FY 1987 construction budget request has been prepared in the context of limited resources for major construction and, in light of the need for fiscal restraint, it is felt that this request is appropriate. Projects of a lower priority which are included in lieu of the five mentioned above are White River Junction, Vermont "Research/Education Building," Dayton, Ohio "Bed Addition/Renovation" and Augusta, Georgia, "Replace VAMC." The Augusta project is included in this budget based on the $12,400,000 already appropriated for its design. The Dayton project is included for design in this budget and is proposed to enable the agency to proceed with the necessary design planning as the construction funding is an integral part of our FY 1988 Budget. In the Conference Report accompanying the FY 1986 Appropriation Bill, the Agency was directed to proceed with the design of the research and education facility at White River Junction, Vermont. As indicated in the Report, the conferees anticipated that the funds for construction would be included in the FY 1987 budget request for major construction. This language was viewed by the Agency as indicative of the Committee's decisions.

Question: 3. With respect to the $4 million included in the minor construction request for nursing home care, please provide an itemization of where the planned conversions of hospital beds to nursing home beds will be made. Please also specify the locations of the 59 beds described on page 5-17 of your budget documents as planned to be converted from hospital care to nursing home care.

Answer: At VAMC Buffalo, 34 hospital beds are to be converted to nursing home care (NHC) beds and at Batavia, 25 hospital beds are to be converted, producing the 59 beds described in the budget documents. Presently, two other projects are scheduled to begin in FY 1987 involving hospital bed conversions to nursing home care beds:

Canandaigua	50 Beds	(80 Gross - 50 net gain in beds)
Miles City	16 Beds	

A search is actively being made for additional hospital bed conversions to nursing home care to utilize remaining budget authority.

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